Supreme Court U.S.
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No.

In The

Supreme Court of the United States

JOHN MANNING REGAN, as a vestee with current employment status, on behalf of himself and all other vestees similarly situated,

Petitioner,

v.

METROPOLITAN LIFE INSURANCE CO.; UNITED HEALTHCARE SERVICES CORP.; and NEW YORK STATE DEPARTMENT OF CIVIL SERVICE,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR WRIT OF CERTIORARI AND APPENDIX

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THE DAILY RECORD

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Rule 14.

(a) Questions Presented

The Record presents no questions of fact. There are only three (3) questions of law presented as follows:

(1) In view if the decision of this Court in Marrese v. American Academy, 470 U.S. 373 (1985), and the concomitant provisions of 28 U.S.C. §1738 both of which held that the preclusive effect of a prior State Court Judgment in a subsequent federal lawsuit must be the same as would obtain in the Courts of the State from which the prior judgment was taken, is, then, the summary order/decision of the 2nd Circuit Court of Appeals below, applying the law of Minnesota to determine the preclusive effect in a subsequent federal action of a prior declaratory judgment of a New York Court, under the circumstances of this case, legally correct?

(2) Whenever a State has, by its Constitution and/or laws governing the jurisdiction of its highest appellate court, provided for the final determination of a question of state law pertinent to judicial proceedings pending in the courts of the United States, by means of a certification to that highest State Court of that question of State law by such United States Courts, then, do the provisions of 28 U.S.C. §1738 compel the Courts of the United States to certify such question of State law to such highest Appellate State Court so long as the answer to such question of State

law may be determinative of the proceedings before those Courts of the United States?

(3) The provisions of Title 42 U.S.C. §300 bb-7 authorize an aggrieved individual who has lost coverage under a Group Health Plan sponsored by a State or Local government to "bring an action for appropriate equitable relief" (A COBRA cause of action). The 11th Circuit Court of Appeals has held this statute bars any claims for costs, fines, or attorneys fees as part of the same cause of action because they are not equitable remedies. Brett v. Jefferson County, 123 F.3rd 1429, at pp. 1434-35 (11th Cir 1997). The Court below, however, has held that in the previous lawsuit in the New York Courts, wherein petitioner herein sued under 42 U.S.C. 300-bb-1 through 300-bb-8, for declaratory, injunctive, and other equitable relief only as 42 U.S.C. 300bb-7 demands, he was required, in that same cause of action, also to sue out an action at law for money damages under the Medicare as Secondary Payer Act (42 U.S.C. §1395y) and, further, that his failure to do so barred his subsequent federal suit for those money damages under the doctrine of res judicata. These holdings constitute fundamentally contradictory rulings of the Circuit Courts, and this Court should determine the proper statutory interpretation of 42 U.S.C. 300bb-7 as it applies to the circumstances of what the Complaint in a COBRA cause of action may plead.

(b) The Parties

The parties herein are as listed in the caption of the Petition.

The Respondents have provided the information regarding their affiliates which appears in the Appendix hereto at pp. A-84.

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A valid and final judgment in an action brought to declare rights or other legal relations of the parties is conclusive in subsequent action between them as to the matters declared, and, in accordance with the rules of issue preclusion, as to any issues actually litigated by them and determined in the action.

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8. Supplemental Relief
Further relief based on a Declaratory Judgment or decree may be granted whenever necessary or proper. The application therefore shall be by petition to a Court having jurisdiction to grant the relief. If the application be deemed sufficient, the Court shall, on reasonable notice, require any adverse party whose rights have been adjudicated by the declaratory judgment or decree, to show cause why further relief should not be granted forthwith.

(d) Citations to the Opinions and orders entered in this case

NONE

(e) Statement as to the Jurisdiction of the Supreme Court of the United States

(1) The Order of the 2nd Circuit Court of Appeals denying the petition for Panel Rehearing was filed on April 8th, 2004.

(2) The Summary Order/Decision of the 2nd Circuit Court of Appeals was filed on November 17th, 2003.

(3) The statutory provision conferring jurisdiction on this Court to review by Writ of Certiorari the orders in this case rendered by the Court below is Title 28 U.S.C. §1254(1).

(4) This petition for Certiorari must be filed within 90 days of April 8th, 2004 to be timely. Rule 13, subparagraph 3.

(f) The Constitutional and Statutory Provisions and Rules involved in this Case

Statutes of the United States:

42 U.S.C. 300 bb-7 – Enforcement

Any individual who is aggrieved by the failure of a State, political subdivision, or agency or instrumentality thereof, to comply with the requirements of this subchapter may bring an action for appropriate equitable relief.

28 U.S.C. §1738

...Such acts records, and judicial proceedings, or copies thereof, so authenticated, shall have the same full faith and credit in every Court within the United States and its Territories and Possessions as they have by law or usage in the Courts of such State, Territory, or Possession from which they are taken.

Statutes of the State of New York

Civil Practice Law & Rules Section 3017(b)

S3017. Demand for Relief

(a) ...

(b) **Declaratory Judgment.** In an action for a declaratory judgment, the demand for relief in the Complaint shall specify the rights and other legal relations on which a declaration is requested and state whether further or consequential relief is or could be claimed and the nature and extent of any such relief which is claimed.

Rules of the New York Court of Appeals:

§500.17 Discretionary Proceedings to review Certified Questions from Federal Courts and other Courts of Last Resort

(a) Whenever it appears to the Supreme Court of the United States, any United States Court of Appeals, or a Court of last resort of any other state that determinative questions of New York law are involved in a case pending before it for which there is no controlling precedent of the Court of Appeals, such Court may certify the dispositive question of law to the Court of Appeals.

Constitution of the State of New York:

Article 6, section 3, subparagraph b.(9)

The Court of Appeals shall adopt and from time to time may amend a rule to permit the Court to answer questions of New York law certified to it by the Supreme Court of the United States, a Court of Appeals Of the United States, or an appellate Court of last resort of another State, which may be determinative of the cause then pending in the certifying Court, and which, in the opinion of the certifying Court, are not controlled by precedent in the decisions of the Courts of New York. [Adopted by the People of the State of New York on November 5th, 1985].

(g) Statement of the Case

Petitioner (hereinafter Regan) filed his federal Medicare as Secondary Payer Act (MSP) complaint in the United States District Court for the Western District of New York on May 7th, 2002. A true copy of this Complaint appears in the Appendix hereto at p. A-47.

The named defendants never filed any Answer to the Complaint. Both defendants moved in August 2002 under F.R.C.P. 12 to dismiss the Complaint on the following grounds:

(1) The Cause of Action is barred under the doctrine of Res Judicata.

(2) The Complaint fails to state a Cause of Action.

(3) The 11th Amendment to the Constitution of the United States bars the Cause of Action.

Prior to submitting their motion for decision by the District Court, the defendants withdrew grounds (2) and (3) above and proceeded only on the Res Judicata grounds.

On March 26, 2003, the District Court granted the motion to dismiss on res judicata grounds. On subsequent Appeal to the United States Court of Appeals for the Second Circuit, that Court affirmed. True copies of the opinion and order of the District Court, and of the Summary Order and Decision of the 2nd Circuit Court of

Appeals appear in the appendix hereto at pp. A-58 and A-72 respectively.

(1) The First Action in State Court

Regan's state court action alleged five separate claims. The fifth claim – against a different defendant from those in this federal lawsuit - alleged medical malpractice on the part of Regan's personal physician, and is, therefore, irrelevant.

The first three causes of action alleged violations of the laws and regulations of the State of New York and, for that reason; they are impertinent, even though the parties were identical.

The fourth cause of action alleged a violation of 42 U.S.C. 300bb-1 through 300 bb-8 on the ground that Regan had experienced a "qualifying event" under Sec. 300bb-3, subparagraph (2), to wit, the termination of his employment with the State of New York. This is hereinafter referred to as Regan's COBRA cause of action.

On all of the first four causes of action Regan sought only Declaratory and Injunctive relief as class action remedies. As an individual remedy, Regan sought specific performance of his health insurance contract in the form of an order directing the defendants to pay his medical bills as his health insurance contract had specifically promised to do.

The singular, foundational fact on all first four causes of action was Regan's loss of his State employment. See paragraph "EIGHTH" of the State Court Complaint.

In compliance with the law of New York, Regan's Declaratory Judgment Complaint also sought injunctive and other relief because C.P.L.R. §3017(b) mandates that such a Complaint must: "state whether further or consequential relief is or could be claimed, and the nature and extent of any such relief which is claimed." Moreover, and in further observance of C.P.L.R. §3017(b), and 42 U.S.C. 300 bb-7, Regan's Complaint asked for specific performance of his personal insurance contract in the form of an order to pay his medical bills, but omitted any action at law for damages.

A true copy of Regan's State Court Complaint appears in the appendix hereto at p. A-1.

The prior State Court Complaint, accordingly, as to the named defendants herein, sought solely equitable remedies; the requested order to Metropolitan to pay Regan's medical bills is an action for specific performance – the money is NOT to be paid to Regan as damages because Regan's Complaint does not allege he has already paid the medical bills, which is a condition precedent to any claim by him for damages.

(2) The Federal Action:

Based on the State Court Complaint's COBRA allegations and the subsequent decision of the State Trial

Judge (Hon. Peter Corning), defendants' F.R.C.P. 12 Motion asked for dismissal of Regan's MSP Complaint in this federal action on the ground that the MSP claim was the same cause of action as the COBRA action Regan had pleaded in State Court. A true copy of Judge Corning's decision and Order appears in the Appendix hereto on p. A-37.

Regan defended against this motion by urging three (3) separate and distinct points, two of which assumed that New York substantive law controlled the outcome of the Motion:

(1) Insofar as it is ascertainable, the law of New York limits the preclusive effect of a Declaratory Judgment Action to the subject matter of the declaratory relief sought. Jefferson Towers v. Public Service Mutual, 195 A.D. 2nd 311 (1st Dept 1993); Coliseum Towers v. Nassau County, 217 A.D.2d 387 (2nd Dept. 1996); Restatement of Judgments #33.

(2) The equitable remedies only Provisions of 42 U.S.C. Sec. 300bb-7 forbid the inclusion of an action at law for damages as part of a cause of action under subchapter XX of Title 42 of the United States Code. Thus the MSP action for damages cannot be brought in the same action and simultaneously with a COBRA action.

(3) The foundational fact of his MSP cause of action is that Regan's employment status with the State of New York law has continued, but the foundational fact of his COBRA claim was that his employment status with the

State of New York has terminated. Thus because of this contradiction, the COBRA and MSP claims cannot be the same cause of action under N.Y. law. Reilly v. Reed, 45 N,Y.2d 24 (1978).

Regan conceded in the District Court that the prior State Court action involved the same parties and Courts of competent jurisdiction, and a final Judgment. He did not concede that the MSP and COBRA claims constituted the same cause of action, and he vigorously argued that the Restatement of Judgment's Declaratory Judgment exception in Rule 33 to the doctrine of res judicata was the law of New York notwithstanding the provisions of C.P.L.R. 3017(b). Moreover, he argued that 42 U.S.C. §300bb-7 forbade the simultaneous pleading of equitable and legal remedies in the same Complaint.

(3) The Declaratory Judgment Exception to Res Judicata

Both the District Court and the Court of Appeals rejected Regan's argument that the Declaratory Judgment exception to the doctrine of Res judicata precluded granting the defendants' motion to dismiss on those grounds. Each court rejected the argument because Regan "previously sought money damages against the defendants" (District Court); and because Regan "sought a variety of coercive relief in his State lawsuit, including an injunction, requiring the defendants to alter their health plans, and attorneys fees and costs" (2nd Circuit Court of Appeals). Both courts assumed the prior action had to seek only declaratory relief.

In doing so, the Courts below adhered to the two-pronged test in the Restatement of Judgments #33 that the prior declaratory judgment action seek only a declaration of rights or legal relations between the parties, and that it NOT seek any coercive relief from the defendants. SEE Restatement of Judgments 2nd, Rule 33, comment c.

Neither Court, below, however, referred to the substantive law of New York as demanded by 28 U.S.C. §1738, and Marrese v. American Academy, supra; both lower Courts relied on Harborside v. Vogel, 959 F.2d 368 (2nd Cir. 1992); and the Second Circuit Court also relied on the law of Minnesota by citing Minneapolis Auto v. City of Minneapolis, 739 F.2d 408 (8th Cir. 1984), which Harborside had also cited.

In Regan's Petition for Rehearing, these egregious errors of law (principally the failure to follow Marrese), were called to the attention of the Circuit Court. The petition also advised of the availability of an order of reference to the Court of Appeals of the State of New York to get a definitive ruling on the impact C.P.L.R. 3017(b) had on the New York law affecting the nature of claim preclusion in a prior declaratory judgment action.

Neither the Uniform, nor the Federal, Declaratory Judgment Acts have a section comparable to C.P.L.R. §3017(b), which compels a N.Y. plaintiff, in a declaratory judgment Complaint, to claim further and consequential relief.

The rule in the Uniform Declaratory Judgment Act, See Uniform Laws Annotated, Master Ed., Vol. 12A, pp. 395-396 (1996) which as of 1993 42 States and the Commonwealth of Puerto Rico have enacted – but New York is not among those adopting States – provides in Section 8 that supplemental relief is available only AFTER the declaratory decree has been granted. The federal statute 28 U.S.C. §2201 permits a declaratory judgment action to proceed "whether or not further relief is or could be sought." Thus, the plenary conditions of Rule 33 of the Restatement of Judgments are compatible only with the laws of those States which do not have a law comparable to C.P.L.R. 3017(b). Intermediate Appellate Courts of New York have, nonetheless, recognized the Declaratory Judgment exception to Res Judicata mentioned in the Restatement, and have, in effect, disregarded the prohibition against pleading coercive relief contained in Rule 33. See Jefferson Towers v. Public Service Mutual, 195 A.D.2d 311 (1st Dept. 1993), and Coliseum Towers v. Nassau County, 217 A.D.2d 387 (2nd Dept. 1996). However, there is, as of this writing, no definitive ruling on that question by the New York Court of Appeals. But what law there is acknowledges the declaratory judgment exception even though a N.Y. declaratory judgment Complaint MUST seek further, and consequential coercive relief, insofar as it is relevant to the "declaration the Complaint has requested." C.P.L.R. §3017(b).

(4) Simultaneous Pleading of The COBRA and the MSP Claims

42 U.S.C. Sec. 300bb-7creates an insurmountable problem for the litigating attorney. In the State Court action, Regan's attorney accepted its limitations to "equitable remedies" quite literally, and alleged no action at law.

Yet the Second Circuit Court has held: §300bb7 does not "suggest that COBRA's equitable relief provision limits the remedies available for claims brought under other statutes as part of the same litigation, whether in federal or state Court. Although Regan's remedies under COBRA were limited to equitable relief, he was free to pursue other remedies for his other claims, and he has not cited any COBRA provision or New York procedural rule that prevented him from simultaneously seeking equitable relief under COBRA and monetary relief for his other claims."

C.P.L.R. §3017(b), however, limits all relief in a Declaratory Judgment complaint to those "on which a declaration is requested." Since Regan asked for a declaration that his employment with the State of New York had terminated, and that such termination was a "qualifying event" under 300bb-3, any other claim predicated on the foundational fact that his employment with the State of New York was still in effect (such as his MSP claim), could not be made part of the same

Complaint. Thus, there clearly was a New York procedural rule barring the pleading of an MSP claim in the original Complaint.

This N.Y. procedural rule, and the limitations of §300bb-7 of Title 42, restricting the original Complaint to equitable remedies only, prohibited Regan from pleading his MSP claim in his prior State Court complaint, and Regan made all those arguments to the Court below in his petition for rehearing.

(h) Argument in Favor of Granting Certiorari

1. Foreword

The three questions presented to this Court as outlined herein on p. i, seriously commingle issues of substantive and procedural law.

The first question asserts that both Courts below, because they failed to follow the choice-of-law procedural rule promulgated in Marrese v. American Academy and 28 U.S.C. 1738, erroneously applied the substantive law of Minnesota to the res judicata issue before them, rather than the law of New York. Minnesota substantive law has adopted the entire Restatement of Judgments Rule 33, including the segment which demands that the first lawsuit seek purely declaratory relief. New York substantive law, insofar as C.P.L.R. §3017(b) and N.Y. case law can be ascertained has not adopted the Restatement's rule in its entirety, because §3017(b) mandates a plaintiff, in a declaratory judgment complaint, to sue for such further and

consequential relief as is appropriate to his requested declaration. The misapplication of the proper substantive law (Minnesota law vs. N.Y. law) has denied petitioner a correct legal judgment on the res judicata issue.

* * *

The second question raises solely an issue of procedural law. Inasmuch as Marrese and 28 U.S.C. 1758 require United States Courts to apply the substantive law of the State from which the judgment in the first action is taken in order to determine its res judicata effect in the second action, the method by which the United States Court is to perform that task becomes an important procedural question. In New York, C.P.L.R. §3017(b) and two intermediate appellate Courts' decisions strongly imply that the Restatement Rule 33 Exception applies in New York notwithstanding the absence of purely declaratory relief in the first action. What is more significant, however, is that New York's Constitution has provided to United States' Courts a procedure by which they may obtain a definitive substantive law ruling on this res judicata issue from the highest Court in New York State. The issue for this Court, then, is whether Marrese and 28 U.S.C. §1738 compel the Courts below to avail themselves of that process.

The third question asks for a definitive ruling from this Court on an issue of statutory interpretation of 42 U.S.C. 300-bb 7 because the 2nd circuit ruling in this case is inconsistent with prior 11th Circuit ruling in another case. Moreover, that final interpretation, whatever it is, will

impact on the res judicata issue as comprehended under New York law. If 300bb-7 bars all actions at law as part of a Cobra claim under Title XX, in the same complaint, then New York substantive law on res judicata must, under the supremacy clause, comply with that interpretation and hold that no action at law can be the "same cause of action" as the one pleaded under COBRA for purposes of res judicata.

2. The Argument

(a) The United States Court of Appeals for the Second Circuit has decided this case contrary to, and in conflict with, the relevant decision of this Court in Marrese v. American Academy, 470 U.S. 373 (1985), and 28 U.S.C. 1738.

Justice O'Connor's opinion in Marrese makes clear that a prior judgment of a State Court can only have, in a subsequent lawsuit in a United States Court, the res judicata effect it would have in the "Courts of the State from which it is taken." Cf. 28 U.S.C. 1738. Accordingly, the 2nd Circuit Court had an obligation to ascertain, and then to apply, the substantive law of New York on whether res judicata applied to Regan's prior State Court judgment, in particular, New York's substantive rules applicable to prior declaratory judgment actions.

The 2nd Circuit Court did not meet that obligation. In its summary decision, it relied almost exclusively on one of its own prior decisions, i.e. Harborside v. Vogel, 959 F.2d 368 (2nd Cir 1992). There was no mention of Marrese, nor of 28 U.S.C. 1738 in its decision.

Harborside was dealing with a prior federal court judgment in a diversity case. In dicta, the Court mused that "federal law should determine the preclusive effect of a federal judgment." It then decided that since both federal and New York law followed the Rule in Restatement of Judgments 33, the outcome would be the same no matter what substantive law was applied.

Harborside then cited Minneapolis Auto v. City of Minneapolis supra, as precedent, but not for the proposition that under Marrese the choice-of-law rule made application of Minnesota law compulsory, but for the proposition that the prior declaratory judgment action had to seek solely declaratory relief, to qualify for the exception in Rule 33 of the Restatement of Judgments. This latter was certainly the substantive law of Minnesota, but it meant nothing as to what was the substantive law of New York.

The Harborside court did not confront the vexatious problem which C.P.L.R. 3017(b) creates in New York. That statute compels a N.Y. declaratory judgment plaintiff to plead coercive relief in his Complaint if: "such further or consequential relief" is applicable to the declaration he has requested. In doing so, a New York declaratory judgment complaint transgresses the duty to plead only declaratory relief as set forth in comment c. to the Restatement Rule 33. That vexatious question Harborside ignored; and that same question the 2nd Circuit also ignored in the instant case. Moreover, when asked to certify the question to the N.Y. Court of Appeals in Regan's rehearing petition, the 2nd Circuit Court refused.

Petitioner concedes that this first point only imposes on this Court a responsibility to police the lower Courts. Some policing is necessary. But observing the Marrese rule in N.Y. is easy since the N.Y. Constitution was amended in 1985 to create a process for a federal Court to employ whenever a vexatious question of State law could determine the outcome of a case before it. The policing authority of this Court, in this case, therefore, need only order the lower Courts to use that process.

(b) Marrese and 28 U.S.C. 1738 compel a federal court to use the process of certifying questions of State law to the highest Court of the State if a definitive ruling on such a State law question may determine the outcome of the case before it.

This is the most important issue in this petition for certiorari. Federal laws, and case law decisions of this Court, frequently demand that in a federal lawsuit the federal Courts invoke the substantive law of a State. Marrese is a prime example: because it demands that the federal Courts give to judgments of State Courts the same preclusive effect as would the Courts of the State from which the judgment originated. Diversity cases in federal courts must apply the substantive law of the State wherein they sit as to all substantive issues in the diversity lawsuit.

New York State, in the early 1980's, recognized, as a consequence of these federal rulings, that it should facilitate the means by which controlling rulings on the substantive law of New York could be obtained by federal

courts, or courts of last resort in sister states, from the highest Court in New York State - the Court of Appeals. To do so, New York amended its own Constitution to provide a mechanism to secure these definitive rulings from the Court of Appeals. It is simple enough: the federal Court must certify the question to the Court of Appeals, and if it does so, the Court of Appeals must answer the question. See N.Y. Constitution, Article 6, section 3, subparagraph b(9).

In New York, two separately elected Legislatures must agree on the text of a Constitutional amendment, and thereafter, the people must vote to approve it. That happened to the above amendment on November 5th, 1985.

The petition for panel rehearing filed in the Circuit Court specifically asked the Court to avail itself of this mechanism since C.P.L.R. §3017(b)'s impact on Restatement Rule 33 has not been decided in the Court of Appeals, and the two Appellate Division decisions from the first and second departments viz., Jefferson Towers and Coliseum Towers, supra, which have ruled that Restatement Rule 33's exception applies in New York, do not discuss the problem 3017(b) creates. Notwithstanding that request, the Circuit Court refused, and denied the rehearing. This error has national implications since it discourages other states from providing a certification mechanism similar to New York's, and encourages federal District and Circuit Courts to apply state laws in the manner of their own choosing, rather than in the manner of choosing by the highest Court of the State.

(c) The decision of the Second Circuit that 42 U.S.C. 300bb-7 did not prohibit Regan from pursuing an MSP action at law for money damages in the same cause of action conflicts with the decision of the 11th Circuit in Brett v. Jefferson County which ruled that only equitable remedies can be pleaded in COBRA lawsuits.

Rule 10's first consideration for granting a petition for a writ of certiorari is a conflict among Circuit Court decisions. Such a conflict appears in this case.

The 11th Circuit in the Brett decision, supra, forbids all claims for costs, fines, or even attorneys' fees in a COBRA lawsuit because they do not constitute equitable remedies.

The 2nd Circuit in the instant case has ruled that Regan must have brought his MSP claim for damages, (an action at law) simultaneously with his COBRA lawsuit, and that his failure to do so has precluded his pleading his MSP claim herein under the doctrine of res judicata.

For the practicing attorney, this is an insoluble dilemma. Only this Court can interpret the limitations to equitable remedies 300bb-7 imposes in COBRA cases on the question whether those limitations forbid joinder of any actions at law for damages in the same complaint.

New York law also has two limiting rules the interpretation of which the Circuit Court should have certified to the Court of Appeals.

The first substantive N.Y. rule is contained in C.P.L.R. 3017(b). That statute limits pleadings in a declaratory judgment action to remedies which arise from the "declaration requested." Regan requested a declaration in his first Complaint that he was no longer a State employee, and, therefore, he could not seek a remedy based on a contradictory declaration, to wit, that he held current employment status with the State as any MSP claim would have required.

Secondly, to enforce claim preclusion in New York both claims must derive from the same "foundational facts." "Where the same foundational facts serve as a predicate for each proceeding, differences in legal theory and consequent remedy, do not create a separate cause of action." Reilly v. Reed, 45 N.Y.2d 24, at p. 30 (1978). In New York, transactional facts and foundational facts are not the same. Regan's foundational fact in his first action was loss of his State employment. In his second action, the foundational fact was his current employment status with the State. Yet the Second Circuit has ruled: "Regan would have been free to assert both his MSP and COBRA claims ... in his State Court action, regardless of the contradictory factual assertions required ... for each claim."

This ruling is inconsistent with the decision of the N.Y. Court of Appeals in the Reilly case, and the Circuit Court should have certified that issue as well to the N.Y. Court of Appeals rather than decide that question of State law itself. Regan also asked the Court to do so in his Petition for Rehearing.

CONCLUSION

For all of the above reasons, petitioner prays that this Court grant the Writ of Certiorari.

Dated: July , 2004

Respectfully submitted,

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APPENDIX

STATE OF NEW YORK
SUPREME COURT COUNTY OF MONROE

JOHN MANNING REGAN, ON BEHALF OF HIMSELF, AND ALL OTHER VESTEES WITHIN THE NEW YORK STATE HEALTH INSURANCE PLAN, WHO ARE SIMILARLY SITUATED;
29 HOYT PLACE
ROCHESTER, NEW YORK

Plaintiff

VERIFIED COMPLAINT
Index No. 90/98

v.

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE, ALBANY, N.Y.; METROPOLITAN LIFE INSURANE CO., 1 MADISON AVE., NEW YORK CITY, NEW YORK; UNITED HEALTH CARE SERVICES CORPORATION, AS ADMINISTRATOR. 505 BOICES LANE, KINGSTON, NEW YORK; AND WILLIAM J. BROREIN, M.D., 2265 SOUTH CLINTON AVE., ROCHESTER, NEW YORK

Defendants.

Plaintiff, by his attorney James A. Robinson, Esq., of counsel to Regan & Regan, P.C., complaining of the defendants on behalf of himself and all other *vestees* of the New York State Health Insurance Plan (NYSHIP) who are similarly situated, allege as follows:

FIRST: Plaintiff is a resident of the State of New York,

County of Monroe and City of Rochester.

SECOND: Upon information and belief, defendants, Metropolitan Life Insurance Co. and United Health Care Services Corporation are corporations licensed to do business in the State of New York, having offices at the addresses indicated above; defendant, New York State Department of Civil Service, is an agency of the State of New York headquartered in Albany; defendant, William J. Brorein, is a physician and a resident of Monroe County.

THIRD: Plaintiff brings this action on behalf of himself and on behalf of all other *vestees* of the New York State Health Insurance Plan similarly situated.

FOURTH: (a) The class of *vestees* is so numerous that joinder of all its members is impractical. A *vestee* in the New York State Health Insurance Plan (NYSHIP) is a former State Employee whose service as a state employee terminated at a time when he was entitled to a vested retirement allowance, but who for whatever reason, at the time of his termination, deferred to a later time the payment of his retirement allowance. This situation happens principally to elected officials whose

term of office ends prior to their eligibility for, or their decision to accept, a retirement allowance, but whose years of service in State employment have entitled them to a vested retirement allowance. Plaintiff herein, at all times hereinafter mentioned, is such a *vestee*. Plaintiff has no way of knowing the size of this class, but alleges that defendant, New York State Department of Civil Service, possesses such information. Upon information and belief, the class contains hundreds of members.

(b) The class was created by the State Legislature in 1966 when, in enacting LAWS, 1966, c. 27 it authorized the President of the Civil Service Department to establish regulations permitting *vestees* to continue to participate in NYSHIP. It originally obliged all *vestees* to pay the full cost of such health insurance coverage, but that provision has since been modified by Laws, 1969 c. 36, which requires the State to pay the insurance premiums for some *vestees*. Regulation 73.1, subparagraph (g), of the Rules and Regulations of the Department of Civil Service acknowledges the status of *vestee* in accordance with the enabling statute.

FIFTH: In this civil action, there are common questions

of law and fact pertinent to the class which predominate over any questions affecting only the individual members of the class.

SIXTH: The claim of the plaintiff herein is typical of the claims of the entire class, and the plaintiff can fairly and adequately protect the interests of the class.

SEVENTH: A class action is superior to other available methods for the fair and efficient adjudication of the issues raised hereinafter in this Complaint.

AS AND FOR A FIRST CAUSE OF ACTION AGAINST THE DEFENDANTS: NEW YORK STATE DEPARTMENT OF CIVIL SERVICE, METROPOLITAN LIFE INSURANCE CO., AND UNITED HEALTH CARE SERVICES CORPORATION, PLAINTIFF ALLEGES:

a. Operative Facts

EIGHTH: Plaintiff served as a State employee from April 6, 1967 until September 28th, 1967 and from January 1st, 1982 until January 1st, 1992, attaining approximately ten and one-half (10 1/2) years of service by January, 1992. At that time, plaintiff, due to expiration of his elected term, left State service, but was vested in entitlement to a retirement allowance, having served the minimum period of ten (10) years.

Accordingly, under Section 163, subparagraph 3, of the Civil Service Law, plaintiff elected to continue tin NYSHIP, as a *vestee*, who was also at that time currently entitled to a retirement allowance, but who deferred receipt of that allowance. Plaintiff was 59 years old at the time he terminated his State employment.

NINTH: The New York State Health Insurance Plan (NYSHIP) is a group health insurance policy. The policyholder is the State of New York, Department of Civil Service, the defendant herein. The insurer, in this case for medical benefits only, is the Metropolitan Insurance Co., co-defendant herein. The beneficiaries are the New York State Employees, active, vested or retired, whose membership constitutes the group. The beneficiaries do not receive a copy of the group health policy. They receive a certificate of insurance, which summarizes the provisions of the policy. Under the rules and regulations of the Department of Civil Service, that defendant has the duty to prepare and distribute these certificates of insurance for its employees, and "such other materials as may be required in connection with the

administration of the Plan." See Rules of the New York State Department of Civil Service Section 73.4.

TENTH: In accordance with his election to continue in NYSHIP, plaintiff continuously made or tendered his premium payment to NYSHIP from January, 1992 through 1997 for himself and his wife. During those years, plaintiff rarely qualified for health benefits and, because of that fact, had little familiarity with the provisions of the plan.

ELEVENTH: Upon information and belief, an important provision of the health insurance plan (NYSHIP) requires *vestee* certificate beneficiaries, and their dependents, to enroll in Medicare when they become 65 years old. The relevant language of the insurance certificate follows:

> "When you are eligible for primary coverage under Medicare the benefits under this plan will change.
>
> Please refer to the General Information section of this book for information on when you MUST enroll for Medicare, and when Medicare becomes your primary coverage. If you and your dependent are eligible for primary Medicare coverage - even if you fail to enroll - your covered medical expenses will be reduced by the amount available under Medicare..."

The referenced language of the general information booklet

(pages 23, 24 and 25) is attached hereto, made a part hereof, and marked Exhibit (1). Two paragraphs of those three pages pertain to the plaintiff as *vestee*. Said paragraphs appear at p. 23 of Exhibit (1). The first paragraph, in the left-hand margin, states:

> "You and your dependents must enroll when eligible for primary Medicare coverage."

The second paragraph appears within the bracketed language on p. 23, and says:

> *Empire Plan Enrollees:* The Empire Plan will not provide any benefits for coverage available under Medicare. If you or a dependent is eligible for primary Medicare coverage but does not enroll, you will be responsible for the full cost of medical services that Medicare would have covered.

Annexed hereto and made a part hereof, and marked Exhibit (2), is the latest amended information booklet language pertaining to vestees and to this topic of Medicare enrollment. That booklet is dated December, 1996 and it advises *vestees* of their duty to enroll in Medicare, when they are eligible.

TWELFTH: Federal laws govern enrollment in Medicare. The pertinent United States Code sections are: Title

42. United States Code, Section 1395 p. A true copy of this section is annexed hereto, made a part hereof, and marked Exhibit (3).

THIRTEENTH: These sections provide for an "**initial enrollment period**" of time when eligible residents of the United States become 65 years of age. The specific section is subparagraph (d) of Section 1395 p. It establishes a seven-month long window of opportunity wherein eligible individuals may enroll in Medicare. This **initial enrollment period** begins three months before an individual attains age 65, and ends seven months later, and enrollment eligibility continues throughout that entire period of time.

FOURTEENTH: The provisions of Federal laws also govern entitlement to Medicare benefits (Medicare B only). The pertinent United States Code sections are: Title 42, United States Code, Section 1395 q. True copies of thee sections are annexed hereto, made a part hereof, and marked Exhibit (4).

FIFTEENTH: Exhibit (4) specifies when entitlement to benefits commences. As appears from the text of Section 1395 q. the date when entitlement to benefits under Medicare B

commences varies in relation to the date of enrollment. If an individual enrolls at anytime in the first three months of this **initial enrollment period**, entitlement begins on the first day of the 4th month; if he enrolls in the 4th month, the first day of the 5th month; if he enrolls in the 5th month, the first day of the sixth month; but if he enrolls in the sixth or seventh month, then enrollment does not begin until the 1st day of the third month after the month of enrollment. Accordingly, the obvious conclusion is that eligibility for enrollment, and entitlement to benefits, are not contemporaneous events in respect to Medicare B benefits under Federal laws.

SIXTEENTH: None of the NYSHIP information booklets which the defendants, Metropolitan Life Insurance Co. or New York State Department of Civil Service, provide to *vestees* mentions these differences in time between enrollment, eligibility and entitlement, and none advises that a seven-month long **initial enrollment period** exists, nor that entitlement varies in time significantly depending upon when, during the **initial enrollment period**, an eligible individual actually applies for Medicare. It is obvious from the statute that coverage

(entitlement) can begin as late as six months after the month in which an individual has had his 65th birthday, and first becomes eligible, or as early as the first day of that month, depending upon the time of enrollment. This exposes *vestees* to the potential risk of a medical health insurance coverage gap of six months' duration if a Medicare eligible *vestee* enrolls in the sixth or seventh month of his **initial enrollment period**; especially if the NYSHIP contract determines that Medicare B benefits coverage begins on the first day of the month the *vestee* becomes eligible because he has turned 65 years of age, thus voiding his NYSHIP medical health insurance coverage for whatever Medicare pays, BEFORE his Medicare has gone into effect. Yet no such putative coverage gap is described in the information booklet, nor is notice of such a gap sent to any *vestee* at or near the time of his 65th birthday.

SEVENTEETH: Plaintiff, whose date of birth is April 18, 1932, enrolled in Medicare at age 65, in July, 1997, during the seventh month of his **initial enrollment period**. Accordingly, his entitlement to Medicare B benefits did not commence, under the federal statute, until October 1, 1997, a

full six-month delay from April 1997, the month in which plaintiff became 65 years of age, and became eligible for entitlement to Medicare benefits.

EIGHTEENTH: On August 4, 1997, during the six-month period between his month of birth (April) and his month of first entitlement to Medicare B benefits (October), plaintiff was diagnosed with rectal carcinoma. For the next six weeks, plaintiff received medical and surgical services from a variety of doctors: internists, gastro-enterologists, radiologists, anesthesiologists, and surgeons, all of whose services constituted Medicare B type services.

NINETEENTH: Upon plaintiff's and the doctors' applications for payment of these medical bills through NYSHIP, the defendant, Metropolitan Life Insurance Co., by its agent, United Health Care Services Corporation, refused to pay. These defendants advised that, according to the New York State Department of Civil Service, co-defendant herein, Medicare B was liable to pay the bills as the plaintiff's primary insurer, since plaintiff had turned 65 years of age in April, 1997.

TWENTIETH: Plaintiff then communicated with the

defendant, New York Department of Civil Service, and advised them that his enrollment in Medicare B occurred during his **initial enrollment period** which Federal law authorizes, but in the seventh month of that period. Accordingly, Medicare B entitlement to benefits did not commence until October 1st, 1997; therefore, medical service rendered in August and September 1997, were not rendered during a Medicare B entitlement period of coverage, and thus Medicare did not have to pay these bills. The defendant, Department of Civil Service, replied in a letter dated 10/16/97 that, since plaintiff had not enrolled in Medicare B "in a timely manner" as the booklet instructed him, the Empire Plan a not obligated to pay the bills.[1] A true copy of this October 16, 1997 letter from defendant, New York State Department of Civil Service, is annexed hereto, and made a part thereof, and marked Exhibit (5).

TWENTY-FIRST: Thereafter, plaintiff wrote to the defendants, Metropolitan Life Insurance Co., and United Health

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[1] Defendant's letter cites an oblique paragraph in the booklet addressed to those who: "are no longer an active employee". In August 1997, plaintiff was working full-time for Monroe County and was making bi-weekly contributions the New York State Retirement System and was in no way inactive.

Care Services Corporation, itemizing his claims for payment of these medical bills, and demanding payment in full. These defendants replied in a letter dated November 5, 1997, that since their records showed plaintiff was eligible to enroll for Medicare benefits in April, 1997, and had not enrolled, defendants were required, under the plan, to reject any medical expenses incurred after April 1, 1997, for which Medicare B would have paid. A true copy of the defendants' letter of November 5, 1997 is annexed hereto, made a part hereof, and marked Exhibit (6).

TWENTY-SECOND: More than 60 days have elapsed since the denial of these claims of plaintiff, and these denials of payment have continued to the date of this complaint.

b. First Cause of Action

(1) State Law Claims

TWENTY-THIRD: Defendants, New York State Department of Civil Service, Metropolitan Life Insurance Co., and United Health Care Services Corporation have failed adequately to perform a duty enjoined upon them by statute, and by administrative rule, and by the standard of care the common law demands. Section 162, subparagraph 5, of the Civil Service

Law requires the defendant Department of Civil Service, to give each *vestee* a certificate "summarizing the provisions of the contract: "principally affecting the employee and his dependents." Rule 73.4 of the Rules and Regulations of the Department of Civil Service require the employer to: "prepare and distribute . . . certificates, and such other materials as may be required in connection with the administration of the plan." Under Article XI of the group insurance policy (contract No. 30500G), the Department of Civil Service has attempted to delegate its statutory duty in this regard to defendant, Metropolitan Life Insurance Co.

TWENTY-FOURTH: The certificates defendants have provided to all *vestees* pursuant to said statutory, common law, and contractual duties, utterly fail to meet the statutory standard, "principally affecting the employee", and the common law standard of reasonable care, and the standard set out in the contents of administrative Rule 73.4 because they: (1) Incorporate federal Medicare benefits enrollment eligibility as the primary insurer under the policy without adequately informing the *vestee* about his **initial enrollment period** under

federal law at the time he turns 65 years of age, and about his obligation to enroll (if there is such an obligation?) within the first three months of said **initial enrollment period**, and about the consequential loss of medical insurance coverage if the *vestee* enrolls in Medicare B in any of the last four (4) months of said **initial enrollment period**. (2) Depend upon detailed provisions of the United States Code differentiating between eligibility, enrollment, and entitlement to benefits which are nowhere mentioned or referenced in the certificates; and (3) fail to provide for a specific notice, before the vestee's 65th birthday, to the *vestee*, at his last known address, that under the pertinent provisions of the United States Code, and the variations between enrollment and entitlement contained therein, that the *vestee* must enroll between the ages of 64 years 9 months, and the month in which he attains 65 years of age, or suffer a gap in his medical insurance coverage of up to six months duration. And plaintiff alleges he received no such notice at any time.

(2) Federal Law Claims

TWENTY-FIFTH: The provisions of Title 42 Section 1395 p and Section 1395 q are the "supreme law of the land,"

and no state laws to the contrary can prevail over them. Accordingly, New York laws which purport to authorize group health insurance contracts which attempt to constrict the length of the "**initial enrollment period**," or to otherwise modify and/or alter the rights conferred under the Medicare statutes to eligible citizens when they attain 65 years of age are incompetent to do so. Only the Congress of the United States has the legislative power to change the term of the **initial enrollment period**, and group health insurance contracts - creatures of State Law - cannot both incorporate the Medicare laws as a primary insurer for group members when they become eligible and then attempt to change the terms and conditions of such Medicare laws, without Congressional consent.

FOR A SECOND, SEPARATE AND DISTINCT CAUSE OF ACTION AGAINST THE NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

TWENTY-SIXTH: Section 167-a of the Civil Service Law requires the defendant, New York State Department of Civil Service, to pay all *vestees*, when they become entitled to coverage under Medicare B, "an amount

equal to the premium charge for such supplemental medical insurance benefits, . . . monthly or at other intervals . . . from the health insurance fund."

TWENTY-SEVENTH: Plaintiff repeats and realleges, with the same force and effect as if fully set forth herein, all the allegations previously set forth in this complaint in paragraphs EIGHTH through TWENTY-SECOND.

TWENTY-EIGHTH: The defendant, Department of Civil Service, must make this premium payment to *vestees*: "upon exclusion from the coverage of the health insurance plan, the supplementary medical insurance benefits" Medicare B provides.

TWENTY-NINTH: Plaintiff alleges that the defendants, New York State Department of Civil Service, Metropolitan Life Insurance Co., and its agent, United Health Care Services Corporation, contend that plaintiff was excluded from coverage Medicare B would provide under the terms of NYSHIP on April 1st, 1997. Accordingly, payment of Medicare premiums to the Plaintiff had to begin on that day. The state's payment of the Medicare B premium is, by la, a condition

precedent to such exclusion from medical coverage under NYSHIP. Nonetheless, defendant New York State Department of Civil Service has not paid plaintiff an "amount equal to the premium charge" for Medicare B, since April 1, 1997. Accordingly, plaintiff's coverage and the coverage of all *vestees* similarly situated under NYSHIP, should continue in force meanwhile.

THIRTIETH: Attached hereto and made a part hereof, and marked Exhibit (7), is a letter from defendant, New York Department of Civil Service, dated November 20, 1997, which purports to contradict plaintiff's allegations in the preceding four paragraphs and to assert payment has been made by the New York State Department of Civil Service.

The statute, Section 167-a, reads, in part as follows:

> "Where appropriate, such amount may be deducted from contributions payable by the employee; . . ."

Certainly the group insurance premium contributions ultimately payable to defendant, Metropolitan Life Insurance Co., must diminish for those certificate beneficiaries whose

primary medical and hospital insurer has become Medicare, as compared to those group certificate beneficiaries whose primary insurer remains Metropolitan. In the latter case, Metropolitan is fully exposed to pay for all the group members' medical expenses. In the former case, however, when Medicare is the primary insurer, Metropolitan's exposure is solely to pay the difference between what Medicare pays (usually 80-85%) and what is the full sum due. Notwithstanding this obvious difference in insurance risk and coverage, defendant, New York State Department of Civil Service, maintains in its letter that group premium contributions to Metropolitan for all *vestees* remains the same regardless of whether a beneficiary's primary insurer is Medicare. Accordingly, defendant states that, when a Medicare covered beneficiary begins to pay his Medicare B premium, he still must also continue to pay, in addition a full premium contribution to Metropolitan. The defendant then, in conformity with the authorization set forth in the statutes, deducts the Medicare B premium payment from to the beneficiary's account obligation with Metropolitan, and either bills the *vestee* only for the difference, or remits to the *vestee*

the surplus. Plaintiff cannot believe these assertions in Exhibit (7) because they defy common sense.

In any event, defendant, New York State Department of Civil Service, has sent plaintiff two checks (for $18.00 each); one in August, 1997, and one in November, claiming that these sums represent the surplus between what plaintiff has paid to Medicare B and what plaintiff owed to Metropolitan. In fact, plaintiff has paid but one Medicare B premium, due in September 1997, for the last calendar quarter of 1997; and has meanwhile tendered premium payments to defendants for the April-October months, but defendants have rejected such tender. In any event, if what defendant, New York State Department of Civil Service, says is true, defendant has paid Metropolitan Life Insurance Co. its full premiums for the period, April - October 1997, and plaintiff should therefore have medical coverage under the group policy.

FOR A THIRD SEPARATE AND DISTINCT CAUSE OF ACTION AGAINST DEFENDANT NEW YORKI STATEDEPARTMENT OF CIVIL SERVICE, METROPOLITAN LIFE INSURANCE CO., AND UNITED HEALTH CARE SERVICES CORPORATION

THIRTY-FIRST: Plaintiff repeats and realleges with the same force and effect as if fully set forth herein all the allegations previously set forth in this complaint in paragraphs EIGHTH through TWENTY-SECOND.

THIRTY-SECOND: The above-named defendants have failed to perform a duty imposed upon them under the terms of the Group Insurance Policy 30,500 G, dated January 1st, 1986, as to which policy terms the plaintiff and all *vestees* similarly situated are third-party beneficiaries.

THIRTY-THIRD: The defendants have agreed among themselves in Exhibit (7) to said contract, which is attached hereto, and made a part hereof, and marked Exhibit (8), to an Empire Plan Communications Program. The main purpose of said plan is to "advise employees of the plan's benefits and features," and to assure that its administrators "have adequate information to administer the program

properly."

THIRTY-FOURTH: In regard to the obligation which the defendants are currently attempting to impose on plaintiff, and on all *vestees* similarly situated, to enroll in Medicare B no later than the first three months of the seven-month **initial enrollment period**, which Federal law has granted to eligible Medicare beneficiaries, the defendants have breached their contractual duty to advise employees of the plan's features because: (1) the information booklets which they provide do not contain this specific information, and (2) the defendants have no program or policy to notify *vestees*, before they turn 65 years of age, that Medicare enrollment and Medicare B entitlement varies with the time of enrollment, and if *vestee* beneficiaries enroll in any of the last four (4) months of their **initial enrollment period**, they shall suffer a gap in medical insurance coverage, which could extend for a period of up to six months, and (3) no administrators of the plan have been told this information to pass on to *vestees*.

FOR A FOURTH, SEPARATE AND DISTINCT CAUSE OF ACTION AGAINST DEFENDANTS, NEW YORI STATE DEPARTMENT OF CIVIL SERVICE, METROPOLITAN LIFE INSURANCE CO., ANDUNITED HEALTH CARE SERVICES CORPORATION

THIRTY-FIFTH: Plaintiff repeats and re-alleges with the same force and effect as if fully set forth herein all the allegations previously set forth in this complaint in paragraphs EIGHTH through TWENTY-SECOND.

THIRTY-SIXTH: The defendants have failed to perform a duty imposed upon them under the provisions of the United States Code: to with the provisions of subchapter XX of Title 42 U.S.C. Section 300 bb - 1 through Section 300 bb-8, which require state governmental group health plans to grant continuation medical insurance coverage to qualified beneficiaries.

THIRTY-SEVENTH: All *vestees*, as hereinabove described and including plaintiff, become qualified beneficiaries under the Act as soon as they terminate their employment with the State under honorable conditions. See Section 300 bb-8, subparagraph (3)(B) of Title 42 of the United States Code.

THIRTY-EIGHTH: Continuation of Group health plan coverage for qualified beneficiaries must extend for a period which begins on the date of the qualifying event (in this case termination), and ending not earlier than:

> (II) the date on which the qualified beneficiary first becomes, after the date of election
> (i) ...
> (ii) entitled to benefits under Title XVIII of the Social Security Act (42 U.S.C. Section 1395, et seq.),

See Title 42 U.S.C. Section 300 bb-2, subparagraph (2) (D).

THIRTY-NINTH: The plaintiff became entitled to benefits under Title XVIII of the Social Security Act on October 1st, 1997, and, since plaintiff was in a governmental group health plan, his coverage under that NYSHIP plan, according to the federal statute, could not end until his entitlement to benefits under Medicare B had begun.

FORTIETH: Accordingly, the NYSHIP plan, even if the Court finds that the group contract authorizes termination of coverage when *vestees* have merely a right to enroll in Medicare, not even when they have a contact duty to enroll,

because such governmental group plan medical insurance coverage must continue to the date of entitlement to benefits in order to comply with federal laws. These federal laws override any NHSHIP contract provision to the contrary.

FORTH-FIRST: Moreover, Title 42 U.S.C. Section 300 bb-6 obligates the defendants, New York State Department of Civil Service, Metropolitan Life Insurance Co. and United Health Care Services Corporation, to notify *vestees*, and their dependents - at the time of commencement of coverage under the group health insurance plan - in writing, of their rights under the federal statute. The defendants have not given plaintiff, as *vestee*, or any other *vestee* similarly situated, written notice that group medical insurance can end only when the *vestee* becomes "entitled to benefits under Title XVIII of the Social Security Act" (42 U.S.C. 1395, et seq.) according to federal law.

FOR A FIFTH, SEPARATE AND DISTINCT CAUSE OF ACTION AGAINST DEFENDANT WILLIAM J. BROREIN, M.D., PLAINTIFF ON HIS SOLE BEHALF, ALLEGES:

FORTY-SECOND: Plaintiff repeats and realleges

with the same force and effect as if fully set forth herein all the allegations previously set forth in this complaint in paragraphs EIGHTH through TWENTY-FIRST.

FORTY-THIRD: Defendant BROREIN was plaintiff's personal physician for about ten (10) years prior to August, 1997. In that capacity, the defendant conducted a complete physical examination of plaintiff on April 17, 1997, the day before plaintiff's 65th birthday.

FORTY-FOURTH: Plaintiff alleges that at the time of this examination he had a bleeding rectal tumor. Plaintiff notified the defendant of his symptoms of rectal bleeding during the examination.

FORTY-FIFTH: Defendant, notwithstanding his knowledge of the symptoms, and is conduct of the physical examination, failed to detect the existence of the tumor, failed to order proper diagnostic tests consistent with the symptomology, and failed to refer the plaintiff to a proper specialist. These omissions constitute medical malpractice as a matter of law, and the certificate required by C.P.L.R. Section 3013-a is attached to this Complaint as Exhibit (9).

FORTH-SIXTH: Plaintiff alleges he is a qualified "party" under C.P.L.R. Section 8602(d) and intends to make application for reasonable counsel fees against the State under Article 86 of the C.P.L.R. and under Article 9 of the C.P.L.R., Section 909.

WHEREFORE, Plaintiff, as *vestee*, for himself, and for all other *vestees* similarly situated, demands Judgment as follows:

1) **On the First Cause of Action:**

(a) A declaratory judgment under C.P.L.R. Section 3001 that the certificates and information booklet provided *vestees* pursuant to the cited statutes, rules and the common law, do not adequately or sufficiently summarize the provisions of the group health insurance contract which principally affect the *vestees* and their dependents because: they do not inform *vestees* that enrollment in the last four months of said period may result in a gap in group health insurance medical coverage; and do not provide for a specific notice to each *vestee* at the time he approaches 65 years of age of these features of the group policy which may adversely affect him, and further

(b) A mandatory injunction against the named defendants requiring them to put this sort of information in their booklet, and to advise their administrators of these features of the group medical policy affecting *vestees* and to issue such notices to *vestees* as above described at the earliest practicable time.

(c) A judgment declaring the state statutes, and the group health contract provisions they authorize, which shorten and constrict the federal Medicare **initial enrollment period** under Section 1395 p and q of Title 42 of the United States Code unconstitutional and void.

(2) **On the Second Cause of Action:**

A declaratory judgment that the defendant, New York State Department of Civil Service, has violated the provisions of Section 167-a of the Civil Service Law because the Department has failed to pay to plaintiff and all other *vestees* similarly situated the premiums they pay for Medicare B benefits, which is a condition precedent for excluding those supplemental Medicare B benefits from the coverage of the group insurance policy and for making Medicare the primary health insurer, and

further a declaratory judgment that *vestees* who pay Medicare B premiums in order to establish Medicare as their primary health insurer do not have an obligation to continue to pay the State the full contract sum premium due under the group health insurance policy, and that, therefore, the credit the defendant, New York State Department of Civil Service, takes for such group health policy premium payment is inappropriate under the statute; and the State must accordingly pay *vestees* the full Medicare premium they pay to Medicare, without the benefit of such deduction, and

(b) A mandatory injunction directing such payment of Medicare B premiums to all *vestees*, as the statute requires, for the past six years.

(3) **On the Third Cause of Action:**

(a) A declaratory judgment that the defendants have breached the terms of the group insurance contract which requires the defendants to advise employees of the plan's benefits and features because they have not advised *vestees* sufficiently and adequately of that feature of the group insurance policy which puts *vestees* at risk of losing group medical

insurance benefits coverage for a period of up to sic months in the event they enroll in Medicare B during the last four months of their federal initial enrollment period. (Title 42 U.S.C. 1395 p), and because they have failed to inform their staff and administrators of this potential gap in group health medical insurance coverage, and

(b) For a mandatory injunction requiring the defendants to inform *vestees* and their staff and administrators, accordingly, pursuant to the provision of the group contract.

(4) **On the Fourth Cause of Action:**

(a) A declaratory judgment that the group insurance policy, 30,500G, insofar as it may provide that its medical insurance coverage ceases when *vestees* become 65 years of age and eligible to enroll in Medicare B regardless of whether, at that time, such *vestees* are entitled to Medicare B benefits, violates the provision of federal law, 42 U.S.C. Section 300 bb-1.through 300 bb-8, because such group medical insurance can only upon entitlement and not upon eligibility to enroll, and further, that the failure to so notify *vestees* in writing at the time of the commencement of coverage violates Section 300 bb-6 of

said statute, and a further declaratory judgment that group medical coverage must continue for such *vestees* until they have entitlement to Medicare B benefits, and

(b) A mandatory injunction directing the defendants to provide continuous coverage of medical insurance benefits under the state's group health policy until the day entitlement to Medicare B benefits begins for such *vestees*, and an injunction requiring defendants to give *vestees* notice to that effect.

(5) **On all of the first four causes of action as incidental relief to the plaintiff, individually, and not as class action relief:**

An Order directing the defendants, New York State Department of Civil Service, Metropolitan Life Insurance Co., and United Health Care Services Corporation to pay in full, with interest form the accrued date due to the date of payment, the medical expenses plaintiff has incurred during August and September, 1997, in connection with his above-described illness; and an Order authorizing the entry of a judgment against those defendants for the full amount so payable, together with the costs, disbursements, and attorney's fees, incurred in this action.

(6) **On the Fifth Cause of Action:**

(a) Judgment against the defendant in the sum of Two Hundred Fifty Thousand Dollars or such larger sum as shall adequately compensate the plaintiff for his injuries and damages.

All of which the plaintiff demands together with the costs, disbursements, and attorneys' fees incurred in the prosecution of this action.

Yours, etc.

REGAN & REGAN, P.C.
BY: JAMES A. ROBINSON, ESQ., Of Counsel
13 South Fitzhugh Street
Rochester, New York 14614

DATED: December 30, 1997

VERIFICATION

STATE OF NEW YORK :
COUNTY OF MONROE : ss.:

I, JOHN MANNING REGAN, being duly sworn, do hereby depose and say that:

I am the plaintiff in the within action; I have read the foregoing Complaint and know the contents thereof; the contents of the Complaint are true to my knowledge, except as to those matters alleged o be upon information and belief, and as to those matters, I believe them to be true.

s/ John Manning Regan
JOHN MANNING REGAN

Sworn to before me this
30th day of December, 1997.

S/ Barbara Ann Lohouse
Notary Public
Comm. Expires 9/30/99

TEXT FROM EXHIBIT (1) TO COMPLAINT

You and your dependents must enroll when eligible for primary Medicare coverage	When you or your covered dependent becomes eligible for primary Medicare coverage, you or your covered dependent must enroll in Medicare Parts A and B. If you do not, your benefits under the Empire Plan or your HMO will be drastically reduced. Empire Plan Enrollees: the Empire Plan will not provide any benefits for coverage available under Medicare. If you or a dependent is eligible for primary Medicare coverage, but does not enroll. you will be responsible for the full cost of medical services that Medicare would have covered.
For all enrollees	...If you are no longer an active employee, contact your local social security office three months before you or your spouse turns age 65, to arrange for enrollment in Medicare Parts A and B. Once you or your spouse has enrolled, Medicare coverage becomes effective on the first day of the month in which you reach 65.

TEXT FROM EXHIBIT (2) TO COMPLAINT

NYSHIP you and/or your covered dependent to enroll Medicare Parts A and B when you/they

- Are age 65 or older, or
- Regardless of age, have been classified by Social Security or disabled for more than 24 months, or
- Regardless of age, have end state renal disease (permanent kidney failure).

If you did not enroll in Medicare Parts A and B when

you were first eligible, you must sign up during the Medicare general enrollment period January 1, through March 31. Your coverage will begin on July 1. Medicare adds a premium charge for late enrollment.

The Empire Plan will not provide any benefits for services that Medicare would have paid for if you had enrolled as required.

See your NYSHIP General Information Booklet for details about Medicare and COBRA enrollment.

Note to COBRA enrollees: Your NYSHIP coverage under COBRA ends when you become eligible for Medicare.

STATE OF NEW YORK
SUPREME COURT COUNTY OF MONROE

JOHN MANNING REGAN, on behalf of himself and all other vestees within the New York State Health Insurance Plan who are similarly situated,

Plaintiff

v.

Index No. 90/98

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE, ALBANY, N.Y.; METROPOLITAN LIFE INSURANE CO., INC.; UNITED HEALTHCARE SERVICE CORP. and WILLIAM J. BROREIN, M.D.

Defendants.

BEFORE: HON. PETER E. CORNING
Acting Justice Supreme Court

APPEARANCES: ELIOT SPITZER
Attorney General of the State of New York
Attorney for the New York State Department of Civil Service
EMIL J. BOVE, JR.
Assistant Attorney General of Counsel
144 Exchange Boulevard
Rochester, N. Y. 14614

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Plaintiff served as a state employee for ten and one half years, from April 6, 1967 to September 28, 1967, and from January 1, 1982 until January 1, 1992. Once he left state service in 1992,he continued to pay health insurance premiums, but rarely used the insurance plan, and was admittedly not familiar with its terms. Specifically, plaintiff alleges that he was unfamiliar with the provision of the New York State Health Insurance Plan (hereinafter NYSHIP) that requires participants who have attained the age of 65 to enroll in Medicare. From the age of 65 on, Medicare becomes the primary insurer, and NYSHIP pays those costs not covered by Medicare. Those who fail to enroll in Medicare must cover the costs of any service which would have been covered by Medicare.

Plaintiff turned 65 on April 18, 1997, but did not enroll in Medicare until July, 1997. Due to his delay, there was a three month waiting period, and his coverage did not commence

until October 1, 1997. Unfortunately, on August 4,1997, plaintiff was diagnosed with rectal carcinoma. Due to his failure to enroll in Medicare on or before his 65th birthday, plaintiff became responsible for certain costs incurred in treating his condition that would have otherwise been covered by Medicare.

This action was commenced on January 6, 1998, when plaintiff filed a complaint against defendants which alleged four causes of action, as follows: 1) the certificate of insurance issued to plaintiff did not adequately inform him of the requirement that he enroll in Medicare Part B, and effectively shortened the length of the initial enrollment period for Medicare benefits; 2) defendant Department of Civil Services failed to reimburse him for Medicare Part B premiums until after his medical claims arose; 3) defendants violated their contractual duties to inform plaintiff of the plan's benefits and features; and 4) defendants violated the provisions of Title 42 USC §300bb-1 through 300bb-8 (hereinafter COBRA) which require that group health plans must extend coverage, after a qualifying event until the beneficiary becomes eligible for

benefits under the Social Security Act. Plaintiff has also brought a medical malpractice action against William J. Brorein, M.D., which is not the subject of the motions currently before this Court.

Defendant first moved for summary judgment in the Summer of 1998. That motion was "denied without prejudice to a renewal thereof upon completion of discovery proceedings" by Justice Henry Scudder. The parties were allowed 120 days to complete discovery. In the interim, Justice Scudder was moved to the Appellate Division, Fourth Department, and this matter was transferred to this Court for resolution. Discovery was ended on or about November 10, 2999, a year after the Order from Justice Scudder giving the parties 120 days to complete discovery.

Defendants have now renewed their motions for summary judgment seeking to dismiss plaintiff's firs and third causes of action on the grounds that plaintiff was well informed of the requirement to enroll in Medicare Part B prior to his 65th birthday, hence, no violations of state law or contractual duties occurred, defendant Department of Civil Service seeks to

dismiss plaintiff's second cause of action on the grounds that all Medicare premiums paid by plaintiff have been reimbursed to him and defendants seek to dismiss plaintiff's fourth cause of action alleging violations of COBRA on the grounds that COBRA is not applicable to the situation at hand.

Plaintiff has countered these arguments by first alleging procedural defects in that the doctrine of "law of the case" precludes this Court from deciding on these issues, as they have already been addressed by Justice Scudder, and that discovery was inappropriately cut short by this Court. Plaintiff then argues again that the Certificate of Insurance did not adequately inform him of the necessity to enroll in Medicare Part B, and alleges violations of COBRA. The Court heard oral argument on this motion on April 24, 2000, and, for the reasons set forth below, has determined that defendants' motion for summary judgment should be granted in its entirety.

To address the procedural concerns raised by plaintiff, this Court is of the opinion that neither argument has merit. The law of the case doctrine which bars a court of coordinate jurisdiction from deciding issues previously decided in another

case is not applicable here. Collins v. Olsher McLain, Ltd. 22 AD2d 485. Justice Scudder specifically contemplated a renewal of defendants' motion for summary judgment once discovery was finished. Furthermore, the issues herein were not decided by Justice Scudder, but were postponed pending the completion of discovery. Therefore, this Court is not now barred from deciding the issues presented herein.

Plaintiff further contends that he was not allowed adequate time for discovery, and that this Court improperly cut the discovery process short. It should be noted that plaintiff had over a year to conduct discovery, and, in that time, admittedly received at least forty pounds of documents from one defendant alone. One year is certainly ample time to conduct any discovery necessary, and this Court was well within its discretion to end the discovery process after that year had passed.

Plaintiff's first and third causes of action basically allege that defendant failed to adequately notify him of the requirement that he enroll in Medicare Part B prior to his 65th birthday. However, plaintiff was informed in over (20) publications and

direct mailings of this requirement. For instance, as plaintiff points out in his brief in opposition to this motion, these publications included such language as "if you are no longer an active employee, contact your local Social Security office three months before you or your spouse turns 65 to arrange for enrollment in Medicare Part A&B." Plaintiff admittedly failed to familiarize himself with the terms of his insurance policy. Given these circumstances, plaintiff cannot now claim that defendants violated their duty to inform him of the requirement to enroll in Medicare Part B. Therefore plaintiff's first and third causes of action based on defendants' failure to inform him of his requirement, are hereby dismissed.

Plaintiff's second cause of action alleges that he has not bee properly reimbursed for the Medicare Part B premiums by defendant Department of Civil Service. Records show, however, that plaintiff has been reimbursed for these expenses. Therefore, this cause of action should be dismissed as well.

The fourth cause of action asserted by plaintiff alleges that defendants violated the provisions of COBRA by failing to extend his insurance coverage until his Medicare Part B

coverage was available. In order to utilize the provisions of COBRA, an insured must first lose insurance coverage due to a certain, enumerated event, such as the termination of employment, or the death of a covered spouse. See 42 U.S.C. §300bb-1. Plaintiff here can point to no such qualifying event. His insurance coverage was never lost, but, rather, it became secondary to Medicare Part B when he reached age 65. Hence, he cannot make an argument that the provisions of COBRA were violated in his case, as these provisions do not even apply to his case.

Accordingly, based upon the foregoing, it is hereby

ORDERED that defendants' motion for summary judgment is granted in its entirely, and that the plaintiff's first, second, third and fourth causes of action are dismissed.

Dated: May 8th, 2000

s/ Peter E. Corning
Peter E. Corning
Acting Justice Supreme Court

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

JOHN MANNING REGAN, as a vestee With current employment status, on behalf of himself, and others similarly situated

SUMMONS
v. IN A CIVIL CASE

METROPOLITAN LIFE INSURANCE CO., UNITED HEALTHCARE CORP-ORATION, and the NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

Case No. 02-CV-6354T(F)

TO: Metropolitan Life Insurance Co.
1 Madison Avenue
New York, New York
Boices Lane

United Healthcare Corp.
505 Boices Lane
Kingston, N.Y.
N.Y. STATE DEPT. of
Civil Service
State Office Building Campus
Building #1
Albany, N.Y. 12239

YOU ARE HEREBY SUMMONED and required to serve upon PLAINTIFF'S ATTORNEY:

REGAN & REGAN, P.C.
Michael J. Regan, Esq. of Counsel
19 Main St. West, Suite 800
Rochester, New York 14614

an answer to the complaint which is herewith served upon you, within thirty (30) days after the service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint. You must also file your answer with the Clerk of this Court within a reasonable period of time after service.

Rodney C. Early
CLERK

May 7th, 2002
DATE

s/M. Chysil
DEPUTY CLERK

Sworn to before me this
26 day of April, 2002

s/Frank S. Pappalardo
Notary Public

Frank S. Pappalardo
Notary Public State of New York
Monroe County
Lic. 02PA6061809
Comm. Exp. Oct. 12, 2005

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

JOHN MANNING REGAN, as a vestee with current employment status, on behalf of himself, and all other vestees similarly situated,
29 Hoyt Place
Rochester, New York 14610

COMPLAINT
CIVIL NO, 02-CV-6254T(F)
CLASS ACTION

Local Rule 23

v.

Metropolitan Life Insurance Co., One Madison Avenue, New York, New York; United Healthcare Services Corp., 505 Boices Lane, Kingston, N.Y.; and N.Y. State Department of Civil Service, Albany, N.Y.

Plaintiff, for his verified complaint, respectfully alleges to this Court, as follows:

FIRST: This case arises under the laws of the United States, to wit: Title 42 United States Code, 1395y, subparagraph (b)(1)(A)(i) and subparagraph (b)(3)(A); and under Title 42 Code of Federal Regulations §411.204. Jurisdiction vests in this Court

under Title 28 U.S.C. §1331. Venue is proper under title 28 U.S.C. §1391, subparagraph (b).

SECOND: Plaintiff is a resident of the City of Rochester, County of Monroe, New York, within the Western District of New York. All events giving rise to the claim hereinafter alleged occurred within the Western District of New York.

THIRD: Defendant Metropolitan Life Insurance Co. (hereinafter Metropolitan) is headquartered in New York City, New York. Defendant United Healthcare Services Corporation (hereinafter United Healthcare) is headquartered, and has a principal place of business in Kingston, New York. Both of these defendants are subject to the jurisdiction of New York Courts of general jurisdiction, and are amenable to service of a summons under F.R.C.P. § 4(K).

FOURTH: Defendant N.Y. State Department of Civil Service is an agency of New York State, is located n the City/County of Albany, N.Y., and is subject to the jurisdiction of courts of general jurisdiction in New York and is amendable to service of a summons under F.R. C.P. § 4(K), and the N.Y. C.P.L.R. §307, subparagraph 2.

FIFTH: Class action allegations are set forth herein n paragraphs 14th through 17th, in accordance with Local Rule 23.

SIXTH: At all times hereinafter mentioned, plaintiff was a contract beneficiary of the New York State Health

Insurance Plan (hereinafter NYSHIP). Under 42 U.S.C. §1395y(b)(1)(B), NYSHIP is a large group health insurance contract. The contracting parties are: the N.Y. Department of Civil Service, one of the defendants herein; and the Metropolitan Life Insurance Co., another defendant herein. The plan administrator is United Healthcare, another defendant herein,

SEVENTH: On our about January 1st, 1992, plaintiff became a NYSHIP contract beneficiary as a *vested employee*. The Rules and Regulations of defendant, Department of Civil Service define this term. Rule 73.1 defines a *vested employee* as: (1) An employee who has enrolled in NYSHIP while employed by the State but who discontinues State service, other than by death or retirement, on or after October 1st, 1966, and (2) remains entitled to receive at a future time a retirement allowance or pension from a plan or system operated by the State of New York, and (3) at the time of his discontinuance of service meets all conditions necessary for the continuance of NYSHIP coverage after discontinuance or retirement. Under N.Y. Department of Civil Service regulation 75.1, such an employee remains a *vested employee* until ..."he commences to receive such retirement allowance or pension, at which time he then becomes a post-retiree." Plaintiff remained a *vested employee*, under NYSHIP until December 12th, 1997, because he discontinued his State service – other than by death or retirement after October 1st, 1966, and remained entitled to receive a pension and to continue in NYSHIP from January 1, 1992 until the present

time, but commenced receipt of his pension on December 12th, 1997.

EIGHTH: Accordingly, while a *vested employee*, plaintiff was eligible for, and covered under, NYSHIP, by virtue of his current employment status. Rule 73.2 of the defendant, N.Y. State Department of Civil Service defines the term employee for NYSHIP purposes. Rule 73.2 provides, in pertinent part, that "for the purpose of continuing coverage under the Plan (NYSHIP) the status of such person as an employee shall be deemed to continue (i) during any period of authorized leave without pay, or while a *vested employee* (emphasis added)." Accordingly, during August and September, 1977, plaintiff was a vested employee under NYSHIP Rules, and was entitled to health insurance coverage thereunder by virtue of his "current employment status."

NINTH: Plaintiff alleges that, at all times hereinafter mentioned, NYSHIP was a large group health plan as that term is defined in Title 42 U.S.C. 1395y, subparagraph (b)(1)(B)(iii) and title 26 U.S.C. 5000(b)(2), without regard to the provision of 26 U.S.C. 5000(d). Large group health plan hereinafter may be cited as LGHP.

TENTH: Under 42 U.S.C. §1395y, subparagraph (1) no large group health plan can "take into account" that an employee who is covered under the plan by virtue of his "current employment status" is entitled to benefits under Title 42, i.e. Medicare. That section prohibits any large group health plan, in this case, NYSHIP, from compelling

its *vested employee* beneficiaries, by contact, to enroll in Medicare when they become entitled to benefits, in order to make Medicare the primary payer of health claims and NYSHIP the secondary payer. That section specifically prohibits such a contract term for all beneficiaries with "current employment status" and mandates that Medicare, in such circumstances as NYSHIP *vested employees possess*, must remain the secondary payer of medical benefits.

ELEVENTH: Notwithstanding the Rules of the N.Y. Department of Civil Service and the federal statutes and regulations above alleged, defendants, acting together in concert, imposed upon your plaintiff, while he was a *vested employee*, a NYSHIP contract duty to enroll in Medicare upon his becoming eligible therefor in April, 1997, and thereafter NYSHIP made itself a secondary payer, and Medicare the primary payer, in violation of the Medicare as Secondary Payer Act, and 42 C.F.R. §411.204.

TWELFTH: (a) In August and September, 1997, when NYSHIP, under the federal statutes and regulations hereinbefore alleged, could not, by its contract provisions with its *vested employees*, make Medicare the primary payer for health insurance claims, and when NYSHIP, as a LGHP, had to remain the primary payer, and Medicare the secondary payer, under such statutes and regulations, the plaintiff sustained substantial medical and hospital expenses as a result of his being diagnosed with carcinoma of the rectum. Plaintiff spent 12 days in the Roswell Park Cancer Institute in Buffalo, N.Y. and incurred medical,

surgical, and hospital expenses in excess if thirty thousand dollars ($30,000). Medicare, and plaintiff, have severally paid these expenses as primary payers; NYSHIP has only paid a small portion of them as a secondary payer, in violation of the statutes.

THIRTEENTH: Under Title 42 U.S.C. §1395y, subparagraph (b)(3), Congress, since 1989, ha provided for a private cause of action for damages, in an amount double that otherwise provided for, whenever a LGHP fails to provide for primary payment (or appropriate reimbursement) in accordance with the terms of the Medicare as Secondary Payer Act. Accordingly, plaintiff demands judgment against defendants for the sum of Thirty Thousand Dollars, with interest from October 1st, 1997, together with the costs and disbursements of this civil action.

CLASS ACTION ALLEGATIONS

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F.R.C.P. §23 and Local Rule 23

FOURTEENTH: Plaintiff brings this action not only on behalf of himself, but also on behalf of all other *vested employees* who are similarly situated, and as to whom NYSHIP has denied primary health insurance coverage by virtue of their being entitled to Medicare benefits at a time when they have incurred medical, surgical, or hospital expenses. Such persons are many in number, and so numerous that joinder of all of them is impractical. The rights which plaintiff alleges under the Medicare as

Secondary Payer Act ad the current employment status of all such *vested employees* under N.Y. Department of Civil Service Rules, as alleged above, constitute common questions of law and fact affecting all such persons.

FIFTEENTH: The claims plaintiff has presented to the Court are typical of the claims to which all *vested employees* are entitled who experience medical/hospital, or surgical expenses, at a time when they are eligible for Medicare benefits. Accordingly, plaintiff will fairly and adequately protect the legal interests of all such *vested employees* as a class.

SIXTEENTH: The prosecution of separate civil actions by individual *vested employees*, seriatim, would, as a practical matter, tend to be dispositive, legally, of the rights and interests of all the other *vested employees* not parties to the adjudication process, or, in the alternative, would seriously and substantially impair their ability to protect such interests as they have. Accordingly, plaintiff asks the Court to find that the common questions of law and fact predominate over any question affecting only individual *vested employees*, and that a class action is superior to any other available process for the fair and efficient adjudication of the issues in this case.

SEVENTEENTH: As a result of all of the above allegations, there are two categories of claimants in the class of "*vested employees*." Category ONE claimants, whom plaintiff seeks to represent, are *vested employees* who, for whatever reason, did not have Medicate coverage

in effect, in whole or in part, at a time when they were eligible for such coverage. As to Category ONE claimants, the individuals themselves became primary payers of their hospital and medical or surgical expenses whenever they sustained such expenses after their Medicare eligibility occurred. Category TWO claimants are those *vested employees* who did have Medicare in effect when they sustained hospital and medical expenses, and paid only nominal amounts towards such expenses, because Medicare paid as the primary payer. As to Category TWO claimants, the proper party in real interest in this action is the United States under 42 U.S.C. §1395y(b)(2)(B)(ii). As to Category ONE claimants, however, the plaintiff is a typical claimant, and a competent representative of the Class.

WHEREFORE, on behalf of himself, and the class of category one *vested employees* he represents, plaintiff demands that the Court:

1. Certify this Action as a Class Action.

2. Order the defendants, N.Y. Department of Civil Service and Metropolitan and United Healthcare to provide plaintiff and the Court with the names and addresses of all *vested employees*, as to whom during the period of six years prior to the date of filing this Complaint, those defendants have denied primary health insurance benefits and/or coverage based upon their eligibility for Medicare benefits under Title 42 U.S.S. 1395 et seq., and thereafter to order defendants to notify all such persons as to the pendency of this action, and the relief requested herein.

3. Ascertain the amounts such vested employees, and Medicare itself, have paid as primary payers for medical, surgical, and hospital expenses incurred during the six years prior t the filing of this Complaint by all of them, and then double such amounts so as to calculate the appropriate sums owed to them by defendants Metropolitan Insurance Co. and N.Y. Department of Civil Service, under the provisions of Title 42 U.S.C. §1395y, subparagraph (b)(3), and upon ascertaining such sums, enter judgment against these defendants on behalf of all the persons in the Class, in the amount of such sums plus interest.

4. Provide, by order, that the Secretary of Health & Human Services have notice of the filing and the allegations of this Complaint so as to "vouch-in" the United States as a party to this civil action.

5. Award such other, further, and different relief as to the Court shall appear just and practical in the premises, including reasonable attorneys' fees.

All of which plaintiff demands together with the costs and disbursements of this action. Plaintiff demands a trial by jury.

DATED: April 30th, 2002.

Yours, etc.

REGAN & REGAN, P.C.
By: s/Michael J. Regan,
of Counsel
19 Main Street West,
Suite 800
Rochester, New York 14614

VERIFICATION

STATE OF NEW YORK:
COUNTY OF MONROE: SS.:

I, JOHN MANNING REGAN, being duly sworn, do depose and say that:

I am the plaintiff in the within action; I have read the foregoing Complaint and know the contents thereof; the contents of the Complaint are true to my knowledge, except as to those matters alleged to be upon information and belief, and as to those matters I believe them to be true.

s/John Manning Regan
JOHN MANNING REGAN

Sworn to before me this
26 day of April, 2002

s/Frank S. Pappalardo
Notary Public

Frank S. Pappalardo
Notary Public State of New York
Monroe County
Lic. 02P A6061809
Comm. Exp. Oct. 12, 2005

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

JOHN MANNING REGAN,

Plaintiff

JUDGMENT
IN A CIVIL CASE

v.

Case Number
02-CV-6254 T

METROPOLITAN LIFE INSURANCE CO.;
UNITED HEALTHCARE SERVICES CORP.,
And NEW YORK STATE DEARTMENT OF
CIVIL SERVICE,

Defendants

X DECISION BY COURT. This action came to hearing before the Court. The issues have been heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED the complaint is dismissed with prejudice.

March 27, 2003
Date

RODNEY C. EARLY
Clerk

Jacqueline Lawreence
(By) Deputy Clerk

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

JOHN MANNING REGAN

Plaintiff,

DECISION
AND ORDER

v.

METROPOLITAN LIFE INSURANCE CO., UNITED HEALTH-CARE SERVICES CORP., and NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

Defendants.

Plaintiff John Manning Regan, ("Regan), a former Rochester City Court Judge, brings this proposed class action lawsuit pursuant to the Medicare as a Secondary Payer law, codified at 42 U.S.C. §1395y, against the New York State Department of Civil Service, the Metropolitan Life Insurance Company ("Metlife"), and the United Healthcare Services Corporation, ("United"). Plaintiff contends that the defendants violated his rights under the Medicare as a Secondary Payer law by failing to pay, as primary insurers, medical costs he incurred in connection with surgery to remove a carcinoma, and follow up care and treatment. Regan contends that the defendants improperly forced him to rely on Medicare as his primary medical insurance, in violation of federal law, which he contends prohibits large group health insurance plans, (such

as defendants' plan), from requiring employees to use Medicare benefits as their primary insurance coverage. He claims that because the defendants required him to use Medicare insurance as his primary insurance, and that because at the time of his medical treatment he was not receiving full Medicare benefits, his claims for reimbursement from the defendants were denied, and he was forced to pay over $15,000.00 in medical expenses. He seeks double damages under the Medicare as a Secondary Payer law for damages he has incurred, and seeks injunctive relief on behalf of a class of persons who have suffered damages as a result of the defendants' requirement that certain employees utilize Medicare as their primary insurance. Defendants move to dismiss plaintiff's complaint on grounds that his claims are barred under the doctrine of res judicata. Defendants argue that the plaintiff had an opportunity to litigate these claims in State Court proceedings that he initiated against the same defendants, in which Regan sought reimbursement for his out-of-pocket medical expenses. Regan's suit was dismissed, and the dismissal was upheld on appeal to the Supreme Court, Appellate Division, Fourth Department. The Court of appeals subsequently denied leave to appeal, as did the Supreme Court of the United States. Defendants argue that because the plaintiff could have brought the instant claims in his state court proceeding, he is barred from asserting those claims in this action.

Plaintiff opposes defendants' motions, and cross-moves to certify this action as a class-action lawsuit. For the

reasons set forth below, defendants' motions to dismiss are granted, and plaintiff's motion to certify a class is denied.

BACKGROUND

I. Factual Background

Defendant John Manning Regan served as a City Court Judge in the City of Rochester from January 1, 1982 to January 1, 1992. During his tenure as a City Court Judge, plaintiff, as a State employee, enrolled in the New York State Health Insurance Plan ("NYSHIP")[1]. When Judge Regan's tenure ended in January 1, 1992, he elected to continue his insurance coverage through NYSHIP, despite the fact that he became employed as a Deputy County Attorney for Monroe County. Under the terms of the NYSHIP plan, retirees were required to enroll in Medicare as of their 65th birthday. Regan, who turned 65 on April 18, 1997, enrolled in Medicare on July 16, 1997, almost three months after he turned 65. Under Medicare rules, Regan became immediately eligible for Medicare Part A benefits, which pay for inpatient hospital care, inpatient care at a skilled nursing facility, and hospice care. However, because Regan did not apply for Medicare benefits prior to

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[1] The New York State Health Insurance Plan is a plan underwritten by defendant Metlife, and administered by defendant United. Defendant New York State Department of Civil Service contracted with Metlife to obtain insurance coverage and benefits for New York State employees. As a former employee, plaintiff Regan is a contract beneficiary of the insurance contract between Metlife and the Department of Civil Service.

reaching age 65, he was subjected to an approximately 3 month waiting period for benefits under Medicare Part B, which pays for medically necessary doctor's services, outpatient hospital services, home health services, and various other services and supplies not covered under Medicare Part A. Accordingly, plaintiff's Medicare Part B benefits did not become effective until October 1, 1997.

On August 4, 1997, plaintiff was diagnosed with rectal carcinoma. Plaintiff underwent treatment for the condition at the Roswell Park Cancer Institute in Buffalo, New York. Plaintiff was a patient at the Institute for 12 days, during August and September, 1997, and incurred over $30,000.00 in medical expenses. Thereafter, he sought reimbursement for his expenses from Medicare and NYSHIP. Medicare, through Medicare art A, paid over $18,000 on behalf of the plaintiff. NYSHIP paid approximately $700.00 dollars, representing the Medicare Part A deductible. With respect to expenses that were subject to Medicare Part B coverage, Medicare refused to reimburse any expenses on grounds that plaintiff (whose Part B coverage would not become effective until October 1, 1997), as not eligible for benefits at the time the medical expenses were incurred. NYSHIP, pursuant to its insurance policy, refused to pay benefits as a primary insurer on grounds that Medicare Part B was Regan's primary insurer, and plaintiff had failed to secure Medicare Part B benefits as was required under his NYSHIP policy. Accordingly, NYSHIP reimbursed plaintiff only those amounts that would not have been covered under Medicare Part B. Plaintiff contends that as a

result of NYSHIP's refusal to pay benefits as a primary insurer, he was forced to incur over $15,000.00 in out-of-pocket medical expenses.

II. Procedural Background

A. State Court Proceedings

Following defendants' denial of benefits, Regan brought an action pursuant to state and federal law against Metlife, United and the Department of Civil Service in New York State Supreme Court, Monroe County. He sought the following relief in that action: (1) a declaratory judgment that defendants had failed to provide adequate notices under federal law to insurance beneficiaries regarding their rights and obligations under the NYSHIP policy; (2) an injunction against the defendants requiring them to properly advise beneficiaries of their rights and obligations; (3) a judgment that certain New York statutes violate Medicare requirements and thus the New York laws are void; (4) a declaratory judgment that the Department of Civil Service violated New York law by requiring plaintiff and similarly situated beneficiaries to pay full health care premiums while simultaneously requiring those beneficiaries to use Medicare as their primary insurer; (5) an injunction requiring defendants to pay Medicare Part B premiums to certain beneficiaries; (6) a declaratory judgment that defendants violated the terms of the group healthcare contract by failing to inform beneficiaries of their rights and obligations under the insurance policy; (7) an injunction ordering defendants to adequately notify

contract beneficiaries of their rights and obligations under the insurance policy; (8) a declaratory judgment that the defendants violated federal law by discontinuing primary insurance coverage of certain beneficiaries who attained the age of 65; (9) an injunction requiring defendants to provide primary insurance coverage to each beneficiary until such time as Medicare Part B benefits begin for that beneficiary; and (10) "an Order directing defendants...to pay in full, with interest...the medical expenses plaintiff...incurred during August and September, 1997..." See Plaintiff's State Court Complaint, attached as Exhibit "B" to the Declaration of Andrew Karamouzis, at pp. 23-28. Plaintiff additionally sought damages against his personal physician for that doctor's alleged malpractice in negligently failing to diagnose plaintiff's rectal tumor.

The crux of Regan's claims against defendants Metlife, United, and the Department of civil Service in the State Court action were that the defendants failed to comply with their obligations under the contract, and under state and federal law to notify him of his responsibility to sign up for Medicare benefits prior to attaining the age of 65. See State Court Complaint at ¶¶ 23, 32, 41. Additionally, he contended that New York State law and the terms of the contract violated federal law by abrogating the federally specified time period for applying for Medicare benefits. See State Court Complaint at ¶ 25. Plaintiff also contended that the defendants violated federal law by failing to continue medical benefits under the

NYSHIP plan until plaintiff's benefits under Medicare Part B commenced. See State Court Complaint at ¶ 36.

On May 8, 2000, acting Supreme court Justice Peter E. Corning granted defendants' motion for summary judgment, and dismissed all causes of action against the Department of Civil Service, Metlife, and United. Judge Corning found that plaintiff had been apprised in over 20 publications and mailings of his duty to obtain Medicare benefits prior to attaining age 65. See May 8, 2000 Decision and Order of Judge Corning at p. 3. Judge Corning dismissed plaintiff's remaining federal claims on grounds that plaintiff was not eligible for relief under those laws because plaintiff had not been subjected to a "qualifying event," (such as termination of his employment), under those laws. Id. At p. 4. On June 8, 2001, the Supreme Court, Appellate Division, Fourth Department, unanimously affirmed Judge Corning's decision. Thereafter, on September 20, 2001, the New York Court of Appeals denied Regan's motion for leave to appeal. Plaintiff petitioned the United States Supreme Court for a Writ of Certiorari, which petition was denied on February 22, 2002.

B. The Federal Action

On May 7, 2002, plaintiff brought the instant action against defendants Metlife, United, and the Department of Civil Service. Unlike the State Court action, in which plaintiff complained that he failed to receive proper notice of his duty to enroll in Medicare prior to attaining age 65,

here plaintiff contends that as a "vestee" under that plan, he was entitled to full benefits under the NYSHIP plan for the period he was considered a vestee, and that the defendants' attempt o make his enroll in Medicare, and refusal to pay benefits as his primary insurers, violates the Medicare as a Secondary Payer law.

DISCUSSION

I. Defendants' Motion to Dismiss

2(b)(6) of the Federal Rules of civil Procedure provides for dismissal of the Complain where the plaintiff has failed to state a claim upon which relief can be granted. When evaluating a Rule 12(b)(6) motion, the court must ascertain, after presuming all factual allegations in the pleading to be true and viewing them in the light most favorable to the plaintiff, whether or not the plaintiff has stated any valid ground for relief. Ferran v. Town of Nassau, 11 F.3rd 21, 22 (2d Cir. 1993), cert. Denied, 513 U.S. 1014 (1994). The court may grant a Rule 12(b)(6) motion only where " 'it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitled him to relief.'" Allen v. WestPoint-Pepperell, Inc., 945 F.2d 40, 44 (2d Cir. 1991) (quoting Conley v. Gibson, 355 U.S. 41, 45-46 (1957)).

Defendants move to dismiss plaintiff's Complaint on grounds that his claims are barred by the doctrine of res judicata. Specifically, defendants contend that because plaintiff could have brought the instant claims in his State

Court action, he is barred by the doctrine of res judicata from asserting those claims in this federal proceeding.

Plaintiff opposes defendants' motions on grounds that the res judicata doctrine does not apply in this case because: (1) he sought only declaratory relief in his State Court action, and res judicata does not apply in cases where the only relief sought is declaratory or injunctive in nature; (2) his claims in the State Court action ere materially different than the claims brought in the instant case; (3) State Courts are not authorized to hear challenges to the Medicare as a Secondary Payer law, and lawsuits under that law may only be brought in federal court; (4) an action pursuant to the Medicare as a Secondary Payer Act could not have been alleged in the State court action because facts supporting that cause of action would have contradicted facts alleged in support of plaintiff's other causes of action; and (5) he did not receive a full and fair opportunity to litigate his claims in State Court.

For reasons set forth below, I find that res judicata applies in this case and bars plaintiff's claims under the Medicare as a Secondary Payer law. Plaintiff's expressed reasons for not bringing the instant claims in his previous State Court action do not excuse his failure to bring those claims in the previous litigation.

II. Plaintiff's Claims are Barred by the Doctrine of Res Judicata

The doctrine of res judicata, or claim preclusion, provides that "a final judgment on the merits of an action

precludes the parties...from relitigating issues that were or could have been raised in that action." Allen v. McCurry, 449 U.S. 90. 94 (1980) (citations omitted) (emphasis added); LaTrieste Restaurant and Cabaret, Inc. v. Village of Port Chester, 40 F.3d 587 (2d Cir. 1994). The purpose of the doctrine is to provide finality to parties who have come before the courts to resolve their disputes. Accordingly, the doctrine prevents relitigation of claims asserted in a previous action, as well as claims (as in this case) that could have been asserted in that action. See Cromwell v. County of Sac, 94 U.S. 351, 352 (1876) (under the doctrine of res judicata, a judgment entered on the merits in a previous action "is a finality as to the claim or demand in controversy, concluding parties and those in privity with them, not only as to every matter which was offered and received to sustain or defeat the claim or demand, but as to any other admissible matter which might have been offered for that purpose").

"It is appropriate to determine whether a complaint is barred by res judicata n a Motion to Dismiss pursuant to Fed.R.Civ.P.12 (b)." Gould v. National Westminster Bank, U.S.A., 2000 WL 1339292, 83 (D. Conn., 2000) (citing Southard v. Southard, 305 F.2d 730, 732 and n. 1. (2d Cir. 1962). To determine whether or not the doctrine of res judicata applies to preclude litigation, the court must determine whether or not the judgment tin the previous action was: "(1) a final judgment on the merits, (2) by a court of competent jurisdiction, (3) in a case involving the same parties or their privies, and (4) involving the same

cause of action." Stephenson v. Dow Chemical Co., 273 F.3d 249 (2nd Cir. 2001) (citing Anaconda-Ericson Inc. v. Hessen (In re Teltronics Servs., Inc. 762 F2d 185, 190 (2d Cir. 1985)) To determine whether or not claims in the second lawsuit involve "the same cause of action", courts determine whether or not "the same transaction or a connected series of transactions is at issue, whether the same evidence is needed to support both claims, and whether the facts essential to the second (action) were present in the first [action]. NLRB v. United Technologies, 706 F.2d 1254, 1260 (2nd Cir. 1983). As stated above,

In the instant case, a final judgment on the merits was issued by a court of competent jurisdiction. Moreover, the State court action in which the judgment was rendered involved the exact same parties. Because three of the four factors for applying res judicata have been met, this court need only determine whether or not the state court action involved "the same cause of action.

Based on the State Court Complaint, and the entire record from the State Court proceedings, I find that the allegations raised in this Complaint could have been raised in the State Court action. The claims in this case, that the defendants violated federal law by requiring plaintiff to enroll in Medicare prior to attaining the age of 65, arise out of the exact facts that were alleged in the State Court action and arise out the same transactions and occurrences that were alleged in the State proceedings. The fact that plaintiff is asserting a new legal theory as a basis of recovery s of no moment, as "[n]ew legal theories do not

amount to a new cause of action so as to defeat the application of the principle of res judicata." In re Teletronics Servs. Inc., 762 F.2d at 193. Accordingly, I find that plaintiff's action is barred by the doctrine of res judicata.

Plaintiff argues that res judicata does not apply in this case because he sought only declaratory and injunctive relief in his State Court action. See Harborside Refrigerated Services, Inc. v. Vogel, 959 F.2d 368, 372-73 (2d Cir. 1992)(recognizing exception to application of res judicata where plaintiff sought only declaratory relief in previous action). Plaintiff's characterization of his previous action, however, as seeking only declaratory and injunctive relief is untenable as the State court Complaint explicitly sought monetary damages against the defendants for their alleged violations of state and federal law. Specifically, plaintiff sought "[a]n Order directing defendants...to pay in full, with interest...the medical expenses plaintiff...incurred during August and September, 1997..." See Plaintiff's State Court Complaint, attached as Exhibit "B" to the Declaration of Andrew Karamouzis, at p. 27. Because I find that plaintiff previously sought monetary damages against the defendants, I find that the "declaratory judgment" exception to the application of the doctrine of res judicata does not apply in this case.

Plaintiff further argues that he should be allowed to maintain this cause of action because he would have been forced to plead contradictory facts in his State court action, and because New York State courts do not have jurisdiction

over claims based on the Medicare as a secondary payer law. Each of these claims is without merit. Courts have long allowed parties to lead in the alternative, and there is no bar in New York to pleading alternative and inconsistent theories of liability. See Two Queens, Inc. v. Scoza, 745 N.Y.S.2d 517, 519 (N.Y.A.D. 1'st Dept., 2002) (noting that pleading in the alternative is expressly permitted under New York C.P.L.R. §§ 3014 and 3017). Additionally, unlike federal courts, which are courts of limited jurisdiction, New York State Courts are courts of general jurisdiction, and may hear and adjudicate federal claims unless federal law grants exclusive jurisdiction over such claims to federal courts. Congress has not provided that Federal courts have exclusive jurisdiction over claims relating to Medicare, and indeed, many of plaintiff's claims in his state court action arose under Medicare. Accordingly, I find that plaintiff has failed to establish that he was barred from bringing all of his claims under Medicare in his original State Court action.

Finally, Regan contends that res judicata should not apply in this case because he did not receive a full and fair opportunity to litigate his claims in state court. Specifically, plaintiff contends that "Judge Corning's rulings on the issue [of discovery] are a disgrace, and that's true notwithstanding the affirmance by the Appellate Division Fourth Department. Plaintiff's Memorandum of Law in Opposition to Defendants' Motions to Dismiss at p. 13. Contrary to plaintiff's conclusory assertion, he did not have an opportunity t fully and fairly litigate his claims in

State Court. Indeed plaintiff exhaustively litigated his claims before the trial court, on appeal, in a motion for leave to appeal to the New York Court of Appeals, and in a petition for a writ of certiorari before the United States Supreme Court. The fact that plaintiff lost on every level des not indicate that he did not have a full and fair opportunity t litigate his claims. Accordingly, I find that plaintiff's contention that he did not have a full and fair opportunity to litigate his claim is without merit.

III. Plaintiff's motion for Class Certification

Because I find that plaintiff has failed to state a claim upon which relief may be granted, I hereby deny as moot plaintiff's motion to certify this action as a class action.

CONCLUSION

For the reasons set forth above, I find that plaintiff could have raised the claims set forth in his Complaint in his previous State Court proceedings. Accordingly, I find that plaintiff's claims in this case are barred by the doctrine of res judicata. Because plaintiff's claims are barred, I find that he has failed to state a claim upon which relief may be granted, and therefore dismiss his Complaint with prejudice.

ALL OF THE ABOVE IS SO ORDERED.

s/Michael A. Telesca
MICHAEL A. TELESCA
United States District Judge

Dated: Rochester, New York
March 26, 2003

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

SUMMARY ORDER

THIS SUMMARY ORDER WILL NOT BE PUBLISHED IN THE FEDERAL REPORTER AND MAY NOT BE CITED AS PRECEDENTIAL AUTHORITY TO THIS OR ANY OTHER COURT, BUT MAY BE CALLED TO THE ATTENTION OF THIS OR ANY OTHER COURT IN A SUBSEQUENTIAL STAGE OF THIS CASE, OR IN ANY CASE FOR PURPOSES OF COLLATERAL ESTOPPEL OR RES JUDICATA.

At a stated term of the United States Court of Appeals for the Second Circuit, held at the Thurgood Marshall United States Courthouse, Foley Square, in the City of New York, on the 17th day of November, two thousand and three.

PRESENT:

HON. RICHARD J. CARDAMONE,
HON. PIERRE N. LEVAL,
HON. SONIA SOTOMAYOR,

Circuit Judges.

JOHN MANNING REGAN, as a vestee with current employment Status, on behalf of himself and all other vestees similarly situated,

Plaintiff-Appellant

v. No. 03-7352

METROPOLICAN LIFE INSURANCE COMPANY, UNITED HEALTHCARE SERVICES CORP., and NEW YORK STATE DEPARTMENT OF CIVIL SERVICE,

Defendants-Appellees.

For Plaintiff Appellant:
MICHAEL REGAN, Burke, Allbright, Harter & Reddy, LLP (Joseph A.F. Valenti, on the brief),Rochester, NY.

For Defendants-Appellees:
ANDREW P. KARAMOUZIS, Moran & d'Arcambal (Aimee P. Levine, on the brief), Rockville Center, NY, for Metropolitan Life Insurance Company and United HealthCare Services Corp.; KATHLEEN M. TREASURE, Assistant Solicitor General (Eliot Spitzer, Attorney General of the State of New York, and Peter H. Schiff, Senior Counsel, on the brief), Albany, NY, for New York State Department of Civil Service.

UPON DUE CONSIDERATION of this appeal from a judgment of the United States District Court for the Western District of New York (Telesca, J.), it is hereby

ORDERED, ADJUDGED AND DECREED that the judgment of the district court is AFFIRMED.

Plaintiff-appellant John Manning Regan ("Regan") appeals from a judgment of the United States District Court for the Western District of New York (Telesca, J.) granting defendants-appellees' motion to dismiss his lawsuit, brought pursuant to the Medicare as Secondary Payer Act (MSPA), 42 U.S.C. §1395Y, as barred under the doctrine of res judicata in light of a prior lawsuit he filed in state court.

On appeal Regan argues that res judicata is inapplicable because: (1) his claims in the previous lawsuit ere not part of the "same cause of action" as the one pleaded in this lawsuit; (2) the claims' mutually exclusive remedies and factual premises prevented him from raising his MSPA claim in the previous lawsuit; (3) his previous lawsuit falls within the "declaratory judgment exception" to claim preclusion; and (4) he was previously not afforded a full and fair opportunity to litigate his claims. Reviewing the district court's decision de novo, we affirm.

First, Regan's MSPA claim is barred by res judicata because it s part of the same cause of action as the claims in his previous lawsuit, and could have been brought as part of that suit. Res judicata bars claims that were or could have been raised against the same defendants in a prior action that reached a final judgment on the merits. L-Tec Elecs Corp. v. Cougar Elec. Org., Inc., 198 F.3d 85, 87-88

(2d Cir. 1999). Under New York's "transitional approach" to determining whether claims are part of the same cause of action for res judicata purposes, "once a claim is brought to a final conclusion, all other claims arising in the same transaction or series of transactions are barred, even if based upon different theories or if seeking a different remedy." Yoon v. Fordham Univ. Faculty and Admin. Ret. Plan, 263 F.3d 196, 200 (2d Cir. 2001) (quoting O'Brien v. City of Syracuse, 53 N.Y.2d 353, 357 (1981)). Whether two claims arise out if the same transaction is determined "pragmatically," by examining whether the claims arise "out of the same act...alleged to be wrongful," seek the "same basic relief," and are so related as to be conveniently tried together. Reilly v. Reid, 45 N.Y.2d 24, 29-31 (1978).

Here, all of Regan's claims arise from the same series of transactions. His state court claims arose out of the defendants' failure to pay for the portion of his August and September 1997 medical expenses that would have been covered by Medicare had he enrolled in it earlier. Regan argued that defendants improperly failed to notify him if the requirement that he promptly enroll in Medicare as his primary health care payer, and that their failure to cover the entirety of his medical expenses after the termination of his state employment violated the Consolidated Omnibus Budget Reconciliation Act amendments to the Public Health Services Act (COBRA). The instant lawsuit is based on the same refusal o coverage; here, Regan asserts that the same defendants violated the MSPA by refusing to cover the Medicare-eligible portion of his expenses,

because he was a "vestee" who maintained current employment status despite having left state service. Though Regan may characterize or emphasize the operative facts differently in the two lawsuits, all of the facts pleaded here were present at the time of his first lawsuit. See Waldman v. Village of Kiryas Joek, 207 F.3d 105, 110-111 (2d Cir. 2000) ("[P]laintiff cannot avoid the effects of res judicata by 'splitting' his claim into various suits, based on different legal theories (with different evidence 'necessary' to each suit)."). Thus, Regan's two lawsuits are based on the same transaction even though they involve differing legal theories, and his MSPA claim is barred by res judicata.

Second, while Regan correctly points out that res judicata will not apply when a plaintiff faces formal barriers to litigating a claim in a previous action, Davidson v. Capuano, 792 F.2d 275, 278 (2dCir. 1986), no such barriers existed in this case. Relying on the fact that the remedies available under COBRA are limited to "appropriate equitable relief," see 42 U.S.C. §300bb-7 (2000), Regan argues that federal law prevented him from asserting any claims for damages (i.e., the MSPA claim) in his initial lawsuit, and that the contradictory factual assertions required by the COBRA and MSPA claims made them mutually exclusive.

Both of these arguments are unavailing. Nothing suggests that COBRA's equitable relief provision limits the remedies available for claims brought under other statutes as part of the same litigation, whether in federal or state

court. Although Regan's remedies under COBRA were limited to equitable relief, he was free to pursue other remedies for his other claims, and he has not cited any COBRA provision or New York procedural rule that prevented him from simultaneously seeking equitable relief under COBRA and monetary relief for his other claims. New York law expressly permits alternative pleading of both claims and remedies, see Two Queens, Inc. v. Scoza, 745 N.Y.S.2d 517, 519 (App. Div. 1st Dep't 2002)(noting pleading in the alternative is permitted under New York C.P.L.R. §§ 3014 and 3017), so Regan would have been free to assert both is MSPA and COBRA claims and requests for relief in his state court action, regardless of the contradictory factual assertions required, and the different relief available, for each claim. We therefore reject Regan's argument that he could not have brought his MSPA claim in the same action as his COBRA claim. See Kiryas Joek, 207 F.3d at 112 n.4 ("[P]rocedural impossibility ... is generally viewed as the necessary predicate for making an exception to res judicata.").

Third, Regan's previous state lawsuit does not fall under the declaratory judgment exception to res judicata. When a prior action "involved only a request for declaratory relief" rather than coercive relief, "the preclusive effect of the declaratory judgment is limited to the subject matter of the declaratory relief sought," permitting a plaintiff to "pursue further to declaratory or coercive relief" in the future. Harborside Refrigerated Servs. Inc. v. Vogel, 959 F.2d 368, 372 (2d Cir. 1992). In

his state lawsuit, however, Regan explicitly sought monetary damages, requesting "[a]n Order directing defendants ... to pay in full, with interest" his unpaid medical expenses as a remedy for several of his claims. State Compl. At 27. In addition to damages, Regan also sought a variety of coercive relief in his state lawsuit, including an injunction requiring the defendants to alter their health plan and attorneys' fees and costs. Having pursued these broad objectives, Regan cannot now argue that his state lawsuit sought only declaratory relief in order to take advantage of the narrow exception to res judicata that allows litigants to prospectively "clarify the legal relationships of parties before they have been disturbed thereby tending towards avoidance f full-blown litigation." Harborside Refrigerated Servs., 959 F.2d at 373; cf. Minneapolis Auto Parts Co. v. City of Minneapolis, 739 F.2d 408, 410 (8th Cir. 1984) (finding declaratory judgment exception inapplicable where plaintiff "sought more than declaratory relief in the original state court suit" by pursuing coercive measures, such as injunctions and other equitable relief).

Finally, we reject Regan's claim that he was afforded a full and fair opportunity to litigate his claims in the original lawsuit because the trial court refused his request to re-open discovery. The trial court provided plaintiff with a lengthy opportunity for discovery and entertained extensive written argument before determining that it would not re-open discovery. Moreover, the additional discovery Regan requested concerning defendants' contractual authority to

require retirees to enroll in Medicare as their primary health care payer would not have affected his ability to make the claim that in doing so defendants violated the MSPA.

For the foregoing reasons, the judgment of the district court is hereby AFFIRMED.

FOR THE COURT:
Roseann B. MacKechnie, Clerk

By: /s/ Lucille Carr

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT
MOTION INFORMATION STATEMENT

DOCKET NUMBER(S):
03-7352

Regan, as Vestee, etc.
v.
Metropolitan Life Insurance, et al

Motion For: Extension of time to file
Relief Sought: Appellant, John Manning Regan asks the Court to extend his time to file a Petition for rehearing until January 5th, 2004 on the grounds set forth in the moving affidavit

Opposing Party:
Metropolitan Life Ins. Co. and N.Y. State Dept. of Civil Service

Moving Party:
Appellant/Petitioner

Opposing Attorney:
Andrew P. Karamouzis,
MORAN &
D'ARCAMBAL,
265 Sunrise HWY,
6th Floor, Rockville
Centre, N.Y. 11570
(516) 678-6660

Kathleen Treasure, c/o
Attorney General, The
Capitol, Albany, N.Y.
12224 (518) 473-7712

Court-Judge/Agency Appealed from: USDC Western District of N.Y.

Has consent of opposing counsel
A. been sought? Yes
B. been obtained? No

Is oral argument requested: No
Has argument date of appeal been set? Yes
Date: November 10th, 2003

Signature of Moving Attorney
/s/ Michael J. Regan Date: November 26th, 2003

Has service been effected: Yes

ORDER

Before: Hon. Richard J. Cardamone, Hon. Pierre N. Leval, Hon. Sonia Sotomayor, Circuit Judges

IT IS HEREBY ORDERED that the motion be and it hereby is GRANTED.

12/16/03
FOR THE COURT:
ROSEANN B. MACKECHNIE, Clerk
By /s/ Arthur M. Heller
Arthur M. Heller, Motions
Staff Attorney

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT
THURGOOD MARSHALL
UNITED STATES COURTHOUSE
40 Foley Square
New York, New York 10007

Roseann E. MacKechnie, Clerk

Date:	4/2/04
Docket Number:	03-7352-cv
Short Title:	Regan v. Metropolitan Life
DC Docket No.	02-cv-6254
DC:	WDNY (ROCHESTER)
DC JUDGE:	Honorable Michael Telesca

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse, Foley Square, in the City of New York, on the 8th day of April, two-thousand four.

Present:

Hon. RICHARD J. CARDAMONE
Hon. PIERRE N. LEVAL
Hon. SONIA SOTOMAYOR
CIRCUIT JUDGES,

JOHN MANNING REGAN, as vestee with current employment status on behalf of himself and all other vestees similarly situated,

Plaintiff-Appellant,

v.

METROPOLITAN LIFE INSURANCE COMPANY, UNITED HEALTHCARE SERVICES CORP. & NEW YORK DEPARTMENT OF CIVIL SERVICE,

Defendants-Appellees.

A petition for panel rehearing having been filed herein by Appellant John Manning Regan.

Upon consideration thereof, it is

Ordered that said petition be and it hereby is DENIED.

For the Court,

Roseann B. MacKechnie, Clerk
By:/s/ Arthur M. Heller
Arthur M. Heller
Motions Staff Attorney

EXHIBIT A

METLIFE, INC.
LIST OF SUBSIDIARIES & AFFILIATES
(AS OF SEPTEMBER 30, 2000)[1]

Wholly-Owned Active Subsidiaries

23RD STREET INVESTMENTS, INC. (DE)
334 MADISON EURO INVESTMENTS, INC. (DE)
BENEFIT SERVICES CORPORATION (GA)
CBNJ, INC. (NJ)
COATING TECHNOLOGIES INTRNATIONAL, INC. (DE)
CONVENT STATION EURO INVESTMENTS FOUR COMPANY (UNITD KINGDOM)
COLLABORATIVE STRATEGIES, INC. (MO)
CONNING, INC. (DE)
CONNING & COMPANY (CT)
CONNING ASSET MANAGEMENT (MO)
CONNING CORPORATION (MO)
COVA CORPORATION(MO)
OVA FINANCIAL SERVICES LIFE INSURANCE COMPANY (MO)
COVA FINANCIAL LIFE INSURANE COMPANY (CA)
COVA INVESTMENT ADVISORY CORPORATION (IL)
COVA INVESTMENT ALLOCATION CORPORATION (IL)
COVA LIFE ADMINISTRATION SERVICES COMPANY (IL)
COVA LIFE MANAGEMENT COMPANY (DE)
COVA LIFE SALES COMPANY (DE)
CP&S COMMUNICATIONS, INC. (NY)
CRB CO., INC. (MA)
CRH CO., INC. (MA)
CROSS & BROWN COMPANY (NY)
ECONOMY FIRE & CASUALTY COMPANY (IL)
ECONOMY PREMIER ASSURANCE COMPANY (IL)
EDISON SUPPLY AND DISTRIBUTION, INC. (DE)
EQUITY INTERMEDIARY COMPANY (MO)
EXETR REASSURANCE COMPANY, LTD. (BERMUDA)
FAIRFIELD INSURANCE AGENCY OF TXAS, INC. (TX)
FIRST CONNECT INSURANCE NETWORK, INC. (DE)

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[1] Gives effect to the sale of Nvest, L.P. and Nvest Companies, L.P. on October 30, 2000.

FIRST COVA LIFE INSURANCE COMPANY (NY)
FULCRUM IFNANCIAL ADVISORS, INC. (MA)
G.A. HOLDING CORPORATION (MA)
GENAM HOLDING COMPANY (DE)
GENAMERICA CAPITAL I (DE)
GENAMERICA CAPITAL I (DE)
GENAMERICA FINANCIAL CORPORATION (MO)
GENAMERICA MANAGEMENT CORPOATION (MO)
GENELCO ASIAPACIFIC LIMITED (HONG KONG)
GENELCO DE MEXICO S.A. DE C.V. (MEXICO)
GENELCO INCORPORATED (MO)
GENERAL AMERICANLIFE INSURANE COMPANY (MO)
GENERAL LIFE INSURANCE COMPANY (TX)
GENERAL LIFE INSURANCE COMPANY OF AMERICA (IL)
GENMARK INCORPORATED (MO)
GENMARK INSURANCE AGENCY OF ALABAMA, INC. (AL)
GENMARK INSURANCE AGENCY OF MASSACHUSETTS, INC. (MA)
GENMARK INSURANCE AGENCY OF OHIO, INC. (OH)
GENMARK INSURANCE AGENCY OF TEXAS, INC. (TX)
HEREFORD INSURANCE AGENCY, INC.(MA)
HEREFORD INSURANCE AGENCY OF ALABAMA, INC. (AL)
HEREFORD INSURANE AGENCY OF IDAHO, INC. (ID)
HEREFORD INSURANCE AGENCY OF MINNESOTA, INC. (MN)
HEREORD INSURANCE AGENCY OF NEW MEXICO, INC. (NM)
HEREFORD INSURANCE AGENCY OF OHIO, INC. (OH)
HEREFORD INSURANCE AGENCY OF OKLAHOMA, INC. (OK)

HEREFORD INSURANCE AGENCY OF WYOMING, INC. (WY)
HYATT LEGAL PLANS, INC. (DE)
HYATT LEGAL PLANS OF FLORIDA, INC. (FL)
INTERACTIVE FINANCIAL SOLUTIONS, INC. (MA)
L/C DEVELOPMENT CORPORATION (CA)
MET LIFE HOLDINGS LUXENBOURG S.A. (LUXEMBOURG)
MET P&C MANAGING GENERAL AGENCY, INC. (TX)
METLIFE AUTO &HOME INSURANCE AGENCY, INC. (RI)
METLIFE CAPITAL CFLI HOLDINGS, LLC (DE)
METLIFE CAPITALCFLI LEASING, LLC (DE)
METLIFE CAPITAL CREDIT L.P. (DE)
METLIFE CAPITAL, LIMITED PARTNERSHIP (DE)
METLIFE CAPTAL TRUST I (DE)
METLIFE CC HOLDING COMPANY (DE)
METLIFE CC HOLDING COMPANY (DE)
METLIFE CENTRAL EUROPEAN SERVICES SPOLKA Z ORGANICZONA ODPOWIEDZIALMOSCIA (POLAND)
METLIFE CREDIT CORP. (DE)
METLIFE EUROOPE I, INC. (DE)
METLIFE EUROPE II., INC. (DE)
METLIFE EUROPE III, INC. (DE)
METLIFE EUROPE IV, INC. (DE)
METLIFE EUROPE V, INC. (DE)
METLIFE FINANCIAL ACCEPTANCE CORPORATION (DE)
METLIFE FUNDING, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF ALABAMA, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF KENTUCKY, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF MASSACHUSETTS, INC. (MA)
METLIFE GENERAL INSURANCE AGENCY OF MISSISSIPPI, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF NORTH CAROLINA, INC. (DE)
METLIFE GENERAL INSURANCE AGENCY OF TEXAS, INC. (DE)

METLIFE HOLDINGS, INC. (DE)
METLIFE (INDIA PRIVATE LTD. (INDIA)
METLIFE INSURANCE COMPANY OF THE PHILLIPINES, INC. (PHILLIPINES)
METLIFE INTERNATIONAL HODLINGS, INC. (DE)
METLIFE INVESTMENTS ASIA LIMITED (HONG KONG)
METLIFE INVESTMENTS LIMITED (UNITED KINGDOM)
METLIFE INVESTMENTS, S.A. (ARGENTINA)
METLIFE NEW ENGLAND HOLDINGS, INC. (DE)
METLIFE SAENGMYOUNG INSURANCE COMPANY LTD. (SOUTH KOREA)
METLIFE SECURITIES, INC. (DE)
METLIFE SECURITY INSURANCE COMPANY OF LOUISIANA (LA)
METLIFE TEXAS HOLDINGS, INC. (DE)
METLIFE TRUST COMPANY, NATIONAL ASSOCIATION (USA)
METPARK FUNDING, INC. (DE
METRIC ASSIGNOR, INC. (CA)
METRIC CAPITAL CORPORATION (CA)
METRIC MANAGEMENT, INC. (DE)
METRIC PRPERTY MANAGEMENT, INC. (DE)
METRIC REALTY (IL)
METROPOLITAN ASSET MANAGEMENT CORPORATION (DE)
METROPOLITAN CASUALTY INSURANCE COMPANY (RI)
METROPOLITAN DIRECT PROPERTY AND CASUALTY INSURANCE COMPANY (RI)
METROPOLITAN GENERAL INSURANCE COMPANY (RI)
METROPOLITAN GROUP PROPERTY AD CASUALTAY INSURANCE COMPANY (RI)
METROPOLITAN INSURANCE AND ANNUITY COMPANY (DE)
METROPOLITAN LIFE HOLDINGS, NETHERLANDS BV (NETHERLANDS)
METROPLOLITAN LIFE INSURANCE COMPANY (NY)
METROPOLITAN LIFE INSURANCE COMPANY OF HONG KONG LIMITED (HONG KONG)
METROPOLITAN LIFE SEGUROS DE RETIRO S.A. (ARGENTINA)

METROPOLITAN LIFE SEGUROS DE VIDA S.A. (URUGUAY)
METROPOLITAN LIFE UBEZPIECZEN NA ZYIE S.A. (POLAND)
METROPOLITAN LLOYDS, INC. (TX)
METROPOLITAN LIFE SEGUROS E PREVIDENCIA PRIVADA S.A. (BRAZIL)
METROPOLITAN MARINE WAY INVESTMENTS LIMITED (CANADA)
METROPOLITAN PROPERTY AND CASUALTY INSURANCE COMPANY (RI)
METROPOLITAN REALTY MANAGEMENT, INC. (DE)
METROPOLITAN RENSURANCE COMPANY (U.K.) LIMITED (UNITED KINGDOM)
METROPOLITAN TOWER CORP. (DE)
METROPOLITAN TOWER LIFE INSURANCE COMPANY (DE)
METROPOLITAN TOWER REALTY COMPANY, INC. (DE)
MEZZANINE INESTMENT LIMITD PARTNERSHIP-8 (DE)
MEZZANINE INVESTMENT LIMITED PARTNERSHIP-BDR (DE)
MEZZANINE INVESTMENT LIMITD PARTNERSHIP-LG (DE)
MISSOURI REINSURANCE (BARBADOS), INC. (BARBADOS)
NAATHAN & LEWIS ASSOCIATES-ARIZONA, INC. (AZ)
NATHAN & LEWIS ASSOCIATES, INC. (NY)
NATHAN & LEWIS OF NEVADA, INC. (NV)
NATHAN & LEWIS SECURITIES, INC. (NY)
NATHAN AND LEWIS ASSOCIATES OHIO, INCOROPORATED 9OH)
NATHAN AND LEWIS ASSOCIATES OF TEXAS, INC. (TX)
NATHAN AND LEWIS INSURANCE AGENCY OF MASSACNUSETTS, INC. (MA)
NATILOPORTEM HOLDINGS, INC. (DE)
NEW ENGLAND INESTMENT MANAGEMENT, INC. (MA)
NEW ENGLAND LIFE HOLDINGS, INC. (DE)
NEW ENGLAND INVESTMENT MANAGEMENT, INC. (MA)
NEW ENGLAND LIFE HOLDINGS, INC. (DE)
NEW ENGLAND LIFE INSURANCE COMPANY (MA)

NEW ENGLAND PENSION AND ANNUITY COMPANY (DE)
NEW ENGLAND SECURITIES CORPORATION (MA)
NEW ENGLAND PORTFOLIO ADVISORS, INC. (MA)
NEWBURY INSURANCE COMPANY, LIMITED (BERMUDA)
N.L. HOLDING CORP. (DEL)(NY)
NVEST CORPORATION (MA)
OMEGA REINSURANCE CORPORATION (AZ)
ONE MADISON INVESTMENTS (CAYCO) LIMITED (CAYMAN ISLANDS)
ONE MADISON MERCHANDISIGN L.L.C. (CT)
PARAGON LIFE INSURANCE COMPANY (MO)
PARK TWENTY THREE INVESTMENTS COMPANY (UNITED KINGDOM)
SECURITY EQUITY LIFE INSURANCE COMPANY (NY)
SECURITY FIRST FINFANCIAL, INC. (DE)
SECURITY FIRST FINANCIAL AGENCY, INC. (TX)
SECURITY FIRST GROUP, INC. (FL)
SECURITY FIRST GROUP OF OHIO, INC. (OH)
SECURITY FIRST INSURANCE AGENCY, INC. (MA)
SECURITY FIRST INSURANCE AGENCY, INC. (NV)
SECURITY FIRST INVESTMENT MANAGEMENT CORPORATION (DE)
SECURITY FIRST LIFE INSURANCE COMPANY
(DE)SEGUROS GENESIS, S.A. (MEXICO)[2]

Companies of which Metlife, Inc. directly or indirectly has actual ownership (for its own account) of 10% through 99% of the total outstanding voting stock.[3]

AMERICAN HORIZON GENERAL AGENCY, INC. (57.2%)(FL)
AMERICAN HORIZON HOLDINGS, INC. (DE)(57.2%)
AMERICAN HORIZON INSURANCE COMPANY (57.2%) (AZ)

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[2] Ownership of Seguros Genesis, S.A. (Mexico) is as follows: Metropolitan Life Insurance Company owns 85.49%, Metropolitan Tower Corp. owns 7.31% and Metropolitan Asset Management Corporation owns 7.20%.

[3] Does not include real estate joint ventures and partnerships of which MetLife,Inc. and/or its subsidiaries is an investment partner.

AMERICAN HORIZON PROPERTY 7 CASUALTY INSURANCE COMPANY (57.2%)(IL)
AMERICAN HORIZON SERVICES, INC. (57.2%)(DE)
BENEFIT RSOURCE LIFE INSURANCE COMPANY (BERMUDA) LTD. (48.13%)(BERMUDA)
DAN RIVER, INC. (32%)(GA)
EXLIPSE CLAIM SERVICES INC. (25%)(CANADA)
FAIRFIELD MANAGEMENT GROUP, INC. (48.13%)(MO)
GRAND CATHAY SECURITIES INVESTMENT TRUST CO., LTD. (20%)(TAIWAN)
GENERAL AMERICAN ARGENTINA SEGUROS DE VIDA, S.A. (57.9%)(ARGENTINA)
GENESIS SEGUROS GENERALES, SOCIEDAD ANONIMA DE SEGUROS Y REASEGUROS (50%)(SPAIN)
GREAT RIERS REINSURANCE MANAGMENT, INC. (48.13%)(MO)
MALAYSIA LIFE REINSURANCE GROUP BERHAD (17.3%)(MALAYSIA)
MERCADIAN CAPITAL L.P. (95%)(DE)
MERCADIAN FUNDING L.P. (95%)(DE)
METRIC COLORADO, INC. (80%)(CO)
METROPOLITAN LLOYDS INSURANCE COMPANY OF TEXAS[4](TX)
METROPLITAN STRUCTURES (50%)(IL)
P.T. METLIFE SEJAHTERA (62%)(INDONESIA)
REGAL ATLANTIC COMPANY (BERMUA) LTD. (57.9%(BERMUDA)
REINSURANCE COMPANY OF MISSOURI, INCORPORATED (57.9%)(MO)
REINSURANCE GROUP OF AMERICA, INCORPORATED (57.9%)(MO)
REINSURANCE PARTNERS, INC. (57.9%)(MO)
RGA AMERICAS REINSURANCE COMPANY, LTD. (57.9%)(BARBADOS)
RGA ARGENTINA, S.A. (57.9%)(ARGENTINA)
RGA AUSTRALIAN HOLDINGS PTY LIMITED (57.9%)(AUSTRALIA)
RGA CANADA MANAGEMENT COMPANY, LTD. (57.9%)(CANADA)

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[4] Affiliate

RGA CAPITAL LIMITED (57.9%)(UNITED KINGDOM)
RGA FINANCIAL GROUP, L.L.C. (35.04%)(DE)
RGA FINANCIAL PRODUCTS LIMITED (57.9%)(CANADA)
RGA HOLDINGS LIMITED (57.9%)(UNITED KINGDOM)
RGA INTERNATIONAL LTD. (57.9%)(CANADA)
RGA LIFE REINSURANCE COMPANY OF CANADA (57.9%)(CANADA)
RGA MANAGING AGENCY LIMITED (57.9%(UNITED KINGDOM)
RGA REINSURANCE COMPANY (57.9%)(MO)
RGA REINSURANCE COMPANY (BARBADOS) LTD. (57.9%)(BARBADOS)
RGA REINSURANCE COMPANY OF AUSTRALIA LIMITED (57.9%)(AUSTRALIA)
RGA REINSURANCE COMPANY OF SOUTH AGRICA LIMITD (57.9%)(SOUTH AFRICA)
RGA REINSRUANCE (UK) LIMITED (57.9%)(UNITED KINGDOM)
RGA SOUTH AFRICAN HOLDINGS (PTY) LTD. (57.9%)(SOUTH AFRICA)
RGA (U.K.) UNDERWRITING AGENCY LIMITED (57.9%)(UNITED KINGDOM)
SANTANDER MET, S.A. (50%(SPAIN)
SEGUROS GENESIS, S.A. (SPAIN)(50%)(SPAIN)
ST. JAMES FLEET INVESTMENTS TWO LIMITED (34%)(CAYMAN ISLANDS)
STATE STREET RESEARCH STRATEGIC PORTFOLIOS: AGGRESSIVE[5] (63.9%)(MA)
STATE STREET RESEARCH STRATEGIC PORTFOLIOS: SMALL CAP VALUE[6] (99.2%)(ma)
TEXAS AMERICAN HORIZON SERVICES AGENCY, INC. (57.2%)(TX)
TRIAD RE, LTD. (32.36%)(BARBADOS)

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[5] Mutual Fund

[6] Mutual Fund

EXHIBIT B

CERTIFICATE OF INTERESTED PARTIES
FOR
UNITED HEALTHCARE CORPORATION

UHC Management Company, Inc.
United Health and Life Insurance Company
United Behavioral Systems, Inc.
UHC TPA, Inc.
Physicians of Georgia, Inc.
United HealthCare of Georgia, Inc.
United HealthCare of Utah
Midwest Physicians Health Programs, Inc.
Physicians Health Plan of Greater St. Louis, Inc.
Physicians Health Plan of the Midwest, Inc.
PrimeCare Health Plan, Inc.
United HealthCare of Ohio, Inc.
All Care, Inc.
All Care Acquisition Co., Inc.
Western Ohio Headquarters
United Health and Life Insurance Company of Ohio
United Health Plans of New England, Inc.
Share Health Plan of Illinois, Inc.
United HealthCare of the Midlands, Inc., f/k/a Share Health Plan of Nebraska, Inc.
United HealthCare of the Midlands Network, Inc. f/k/a Share Health Care, Inc.
Chicago HMO, Ltd.
United Health and Life Insurance Company of Illinois f/k/a Chicago Health Multi Option Insurance, Ltd.
FOCUS Healthcare Management, Inc.
Complete health Services, Inc.
Complete Health, Inc.
Alabama Health Network, Inc.
Complete Health of Alabama, Inc.
Complete Health of Arkansas, Inc.
Complete Health of Georgia, Inc.
Complete Health of Mississippi, Inc.
Complete Health of Tennessee, Inc.
Dental Benefits Management, Inc.

CompManagement, Inc.
Rx Management, Inc.
Complete Health Partners, Inc.
Community Health Network of Louisiana, Inc.
Louisiana Health Partners, Inc.
Complete Health of Louisiana, Inc.
Lousiana Health Management Company
Ramsay-HMO Inc.
Ultima RX, Inc.
Ramsay Life and Health Insurance Company
Employers Insurance Services Group, Inc.
CAC Management, Inc.
CAC-Properties, Inc.
CAC - United HealthCare Plans of Florida, Inc. f/k/a CAC-Ramsay Health Plans, Inc.
United HealthCare Plans of Florida, Ind. f/k/a C.A.C. Health Plan, Inc.
United Medical Group, Inc.
Ramsay Health Plans (Puerto Rico), Inc.
GenCare Health Systems, Inc.
GenCare Management Company
GenCare Preferred Provider Organization, Inc.
GenCare Dental Plan, Inc.
Group Sales and Service of Puerto Rico, Inc.
The MetraHealth Insurance Company (Ins)
MetraHealth Management Corporation
MetraHealth Care Plan of Arizona, Inc.
MetraHealth Care Plan of California, Inc.
MetraHealth Care Plan of Colorado, Inc.
MetraHealth Care Plan of Florida, Inc.
MetraHealth Care Plan of Illinois, Inc.
MetraHealth Care Plan of Kansas City, Inc.
MetraHealth Care Plan of Kentucky, Inc.
MetraHealth Care Plan of Massachusetts, Inc.
MetraHealth Care Plan of New Jersey, Inc.
MetraHealth Care Plan of New York, Inc.
MetraHealth Care Plan of Ohio, Inc.
MetraHealth Care Plan of Pennsylvania, Inc.
MetraHealth Care Plan of St. Louis, Inc.
MetraHealth Care Plan, Inc.
MetraHealth Care Pan of Virginia, Inc.

MetraHealth Care Plan of Wisconsin, Inc.
MetraHealth Insurance Company of New York
The MetraHealth Employee Benefits Company, Inc.
MetraRealty, Inc.
The MetraHealth Care Holding Company
The MetraHealth Care Network, Inc.
MetraHealth Care Plan of Greater Chicago, Inc.
MetraHealth Care Plan of Louisiana, Inc.
MetraHealth Care Plan of Upstate New York, Inc.
MetraHealth Care Plan of Texas, Inc.
ProAmerica Managed Care, Inc.
The MetraHealth Telebrokerage, Inc.
United HealthCare Administrators, Inc.
MetraComp, Inc.
MetraHealth Pharmacy Management, Inc.
The Center for Corporate Health, Inc.
U.S. Behavioral Health
U.S. Behavioral Health Plan, California
Behavioral Health Administrators
MetraHealth Service Corporation
HealthSpring Inc.
HealthSpring of Pennsylvania, Inc.
HealthSpring of Georgia, Inc.
HealthSpring of Ohio, Inc.
Healthspring of Illinois, Inc.
MetLife Group Administrator, Inc.
Corporate Health Strategies, Inc.